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ABSTRACT

Within the past decade, the field of marriage and family therapy has mushroomed. As a new and emerging professional specialization, marriage and family therapy is subject to control struggles as well as the proliferation of training modalities. This monograph, written for counselor education faculty, students, and family therapists, provides literature on select areas of marriage and family therapy (i.e., systems issues; training and supervision; and alternative family lifestyles) as they pertain to counselor education. The section on systems issues explores four aspects of program implementation: curricula and program development; accreditation requirements for the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the American Association of Marriage and Family Therapy (AAMFT); integration of marriage and family therapy into counselor education; and gender issues of family systems therapists. The section on training and supervision focuses on clinical training in family psychology and supervision from four perspectives: collegial process; a review of current practice; supervisee's perspective on live supervision; and the reflections of a supervisor. The alternative family lifestyles section addresses the training of divorce counselors and single parent family counseling. A list of references follows each article. (BL)

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Issues in Training Marriage and Family Therapists

Editors
Barbara F. Okun and
Samuel T. Gladding

Association for Counselor Education and Supervision

ERIC Counseling and Personnel Services Clearinghouse
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ISSUES IN TRAINING MARRIAGE AND FAMILY THERAPISTS

Barbara F. Okun and Samuel T. Gladding
Editors

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PREFACE

Professional training in marriage and family therapy emanates from many disciplines, including pastoral counseling, social work, psychiatry, psychology and counselor education. As a result, there are several professional organizations such as the American Association for Marriage and Family Therapy (AAMFT), American Psychological Association (APA), Association of Family Therapists (AFTA), National Association of Social Workers (NASW) and American Personnel and Guidance Association (APGA) concerned with the training and practice of marriage and family therapy. For counselor educators, the major competition for professional affiliation lies between APGA (in particular, the Association for Counselor Education and Supervision, ACES), Division 17, Counseling Psychology of APA, and the AAMFT. Counselor educators interested in marriage and family therapy often experience identity confusion as they struggle with the choice of professional affiliation and with the professional competition arising from credentialing and political and economic pressures on helping professions.

Within the past decade, the field of marriage and family therapy has mushroomed. The term "marriage and family therapist" is now recognized by the public and the government. The numbers of both individuals claiming this designation and the literature within the professional journals have increased significantly. As a new and emerging professional specialization, marriage and family therapy is subject to control struggles as well as the proliferation of training modalities.

In recent years, ACES has shifted its emphasis from training school counselors to educating community counselors, including marriage and family therapists. There is a noticeable movement within counselor education departments to provide marriage and family therapy courses and/or programs within their curricula. Members of APGA have noticed the piecemeal presentation of articles concerning marriage and family therapy in the various national and divisional publications. While special issues of The School Counselor and Elementary School Guidance and Counseling have been devoted to this subject, for the most part, articles dealing with marriage and family therapy have been scattered among journals such as the

Personnel and Guidance Journal and Counselor Education and Supervision. In other words, within APGA, no one division or group has focused clearly on this area.

Given these facts, ACES President Thomas M. Elmore appointed a special committee within ACES on marriage and family therapy with Barbara Okun as the chairperson. As word of the formation of this committee spread, interested counselor educators sought involvement. This monograph grew out of the work of this committee.

The purpose of this monograph is to provide literature on select areas of marriage and family therapy as they pertain to counselor education. The monograph is intended for counselor education faculty and students as well as family therapists from other disciplines.

There are three overall goals of the monograph. The first is to explore possibilities of the unique contributions counselor educators can make to research, training and practice of marriage and family therapy. Whereas most of the research, training and practice comes from other disciplines, there are enough overlaps among all of the helping professions to allow for counselor educators' input. A second goal is to disseminate among counselor education staff and students a sample of the type of research, theory and practice currently conducted by counselor educators. A third goal is to generate active involvement by ACES counselor educator, supervisor and student members in the development of marriage and family therapy and its literature as a special interest area.

As editors, we would like to thank Tom Elmore, President of ACES, for his continued support and encouragement. We also want to thank our contributing writers for their enthusiastic involvement and their adherence to stringent deadlines. Debbie Herbert and Garry Walz at ERIC/CAPS have provided painstaking editorial and production support.

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I. SYSTEMS ISSUES

Many departments of counselor education are attempting to incorporate marriage and family counseling training programs into their departmental structure. For some, this means the inclusion of one or two marriage and family counseling courses; for others, it might represent the availability of a sequence of specialized courses with supervision; and for still others, it may represent an attempt to develop a complete training program. In addition to the turf issues between professional associations and departmental factions referred to in the Preface, there are other systems issues that impede new program implementation and development.

The four articles in this section begin to address these systems issues and show that even the smallest attempts to change are often resisted by well-meaning colleagues or by larger systems (such as the full department or the college in which the department resides). Likewise, small changes reverberate throughout larger systems and can result in disruption or a degree of larger order change. We know that systems resist changes and hold tenaciously to established homeostatic mechanisms to preserve the status quo. Some of these homeostatic mechanisms may be manifested in the denial by some faculty of a need to change course, the opposition by some to new course proposals, the resistance by administrators to put changes on committee agendas, the insistence on adherence to conventional forms of supervision when no longer viable, or a refusal by faculty to take advantage of re-training opportunities in new and emerging professional areas. In order to cope with the inevitable frustrations from within and without the department, it is important for students and faculty to coalesce and work together.

Joanne Cooper and Stan Charnofsky of California State University-Northridge relate their institution's process in starting a marriage and family counseling program. Recognizing resistance to change, members of their department began program development unofficially by offering courses in "family life education" and including an interdisciplinary component to the program. With sensitivity and humor, they trace the successful development of their program and model integration of "old" and "new" ways of thinking and doing. Programmatic change must consider the needs and concerns of faculty, students, therapists and clients as well as those of the larger society. Ongoing responsiveness to an everchanging society necessitates ongoing assessment and change.

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Many counselor educators involved in marriage and family counseling are divided in their loyalties to the American Association for Marriage and Family Therapy (AAMFT) and the American Personnel and Guidance Association (APGA), particularly the division of the Association of Counselor Education and Supervision (ACES). This loyalty tension becomes more important as one considers issues of accreditation and credentialing. The AAMFT standards for the training of marriage and family therapists have proven themselves over time and provide rigorous, specialized criteria for training. Very few counselor education programs currently have AAMFT accreditation, but it is likely that this type of program accreditation will become mandatory in order for program graduates to be eligible for licensure or certification as marriage and family counselors or therapists.

Michele Thomas of Tennessee State University is very concerned about the issue of accreditation and compares curriculum and faculty qualification requirements between APGA's Council for Accreditation of Counseling and Related Educational Programs (CACREP) and AAMFT. The CACREP standards are more general than those of AAMFT and are too new to evaluate in terms of practicality and viability. Thomas concludes that it may be most practical and feasible for counselor education departments to acquire both CACREP and AAMFT accreditation and that careful attention to the standards will reveal common areas as well as divergencies.

Alan Hovestadt, David Fennell and Fred Piercy* from East Texas State University have developed a counselor education department marriage and family therapy program that is accredited by AAMFT. They suggest three varying levels of involvement in marriage and family therapy training, depending upon the counselor education's level of commitment and investment. Like Thomas, they suggest that dual affiliation with APGA and AAMFT might be the most desirable stance for counselor education departments in order to retain their unique approach to marriage and family therapy training. If all counselor education departments mirror the existing programs with AAMFT accreditation, the rich heritage of the developmental, non-medical approach to counseling and therapy may fade.

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*Currently at Purdue University.

Obviously, much energy and availability of resources is required from a university system in order to allow programs to become eligible for CACREP and AAMFT accreditations. Many universities will be reluctant to make this investment until they see the direct linkage between program accreditation and licensure and job eligibility.

Another type of systems change is discussed by Barbara Okun of Northeastern Universty in "Gender Issues for Family Systems Therapists." She points out that family therapy surfaces sex-role biases on the part of therapists and clients more readily than more conventional forms of therapy. Counselor education faculty need to acknowledge personal and departmental gender issues in order to provide direct coverage of these issues and their implications in curriculum and supervision of family systems therapists. As most departments of counselor education are dominated by male value systems and reside in male-dominated colleges and universities, attention to gender issues has been sporadic and inconsistent. Resistance to change is particularly strong in areas where values and power structures are questioned.

Students and faculty must work together to develop effective programs. Consideration and elaboration of how these issues presented in this section relate to individual students, faculty and programs may prove beneficial to the process of strengthening embryonic and more established marriage and family counseling programs within departments of counselor education.

Curricula and Program Development in Marriage and Family Counseling: Process and Content

Joanne Cooper
and
Stan Charnofsky

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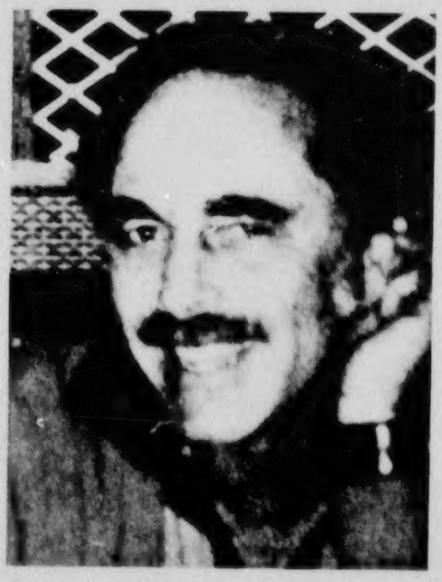

CURRICULA AND PROGRAM DEVELOPMENT IN MARRIAGE AND FAMILY COUNSELING: PROCESS AND CONTENT

INTRODUCTION

Counselor education programs nationwide are facing severe pressures that may endanger their very existence. Most programs are housed in departments or schools of education, though the majority of graduates are now finding employment in non-school settings (Elmore, 1982). Therefore, there is a need for a comprehensive assessment to determine if our programs meet the changing goals of our students. It is likely that for now and in the foreseeable future the task will be to develop counselors who can serve a broader segment of society.

In attempting to reach this broader base, counselor education departments are being confronted with the necessity of providing students with skills and competencies in counseling families and couples. In a recent nationwide random survey, it was found that most counselor education departments already had a relatively high level of involvement in marriage and family counseling preparation, with an indication of increased involvement in the future (Meadows & Hetrick, 1982).

SEEING THE TREES FOR THE FOREST: THE PROCESS OF CURRICULA AND PROGRAM DEVELOPMENT

In focusing on curricula and program development in counselor education, we are facing the dual issues of transformation and change within ourselves as individuals, and change of the academic systems in which we work. We have learned to conceptualize broadly in all academic disciplines. Curricula development, however, requires that we look at each small element of a program to conceptualize how these elements interrelate.

The Perils of Innovation and Change in Academia

Institutions of higher education are usually ill-suited for innovation and change because they are founded on and supported by traditional values. Although faculty are acknowledged to hold authority over curriculum matters, the administration, controlling the resources of the institution, often determines the policies underlying curricula decisions.

According to Wheelis (1973), change is initiated only when it is clear that the a priori ingredient of suffering exists. Once suffering is acknowledged, the three steps in change are: awareness, desire and action.

There are many indications today that academic institutions and their faculties are suffering sufficiently, and are now aware enough to demand some kind of curricular and program change. While very few materials are available in the literature on curricula development in counselor education, two models, one older and one relatively new, have provided us with ideas that can be applied in the education of marriage and family therapists.

Traditional Curricula Development

Traditional approaches to program development were described by Tyler (1949) three decades ago. Though acknowledging the importance of widespread faculty participation in curricula building, Tyler focused on the goals and purposes of each educational experience from the viewpoint of student and societal need. In this model, the focus remains on thoroughly described and specifically outlined academic goals and objectives. There is, however, little emphasis on resources within the faculty, and how those resources might be developed.

A Systems Approach to Curricula Development

In contrast to Tyler's traditional approach, Gimmestad (1976) explores the advantages of using a systems approach to curricula revision. According to Gimmestad, the faculty at Florida State University chose to build a curriculum based on a systematic study of client needs. The most difficult aspect of this systems approach proved to be the translating of information obtained into a workable set of realistic academic goals. Implementation was also difficult. Faculty members were required to develop new courses. Field placement sites had to be expanded to accommodate increased practicum requirements.

Neither approach described above addresses two serious problems that can arise from self-assessment. First, faculty typically are rewarded for time spent in research and publication and are not recognized or rewarded for efforts at program development. Second, self-assessment can interfere with close collegial relationships because of the threat experienced during such peer scrutiny. Faculty typically grow defensive when being assessed, often justifying current practices, rather than seeking new content for the curriculum.

Toward Resource-Based Program Development

A third alternative to curricula and program development begins with an assessment of current faculty orientations, as well as the projected goals and professional interests of each faculty member. The Educational Psychology Department at California State University, Northridge, is currently undergoing a resource-based process of program development. A long-range planning committee was established to interview each member of the faculty. A list of faculty resources was compiled, together with each faculty member's assessment of expected length of service to the department, and areas in which he or she felt the need or desire to retool. Such an assessment seemed critical in developing curricula in a well-established department where few new faculty hirings were anticipated. Overall goals and objectives of the department were established from the list of goals compiled by the interviewers.

An essential aspect of this model is the identification of current attitudes that support the existing program. These attitudes are carefully evaluated to determine how they intermesh among the several members of the faculty, and how compatible they are with the overall mission of the university.

Using this model, and establishing a new faculty focus, the department was able to determine those curricular areas that needed changing and could employ the systems analysis approach alluded to above. Exploring values through a systematic needs assessment is essential. Rather than focus initially on the ideal curriculum, there must be a complete analysis of how the faculty functions in such areas as academic training, experiences and problem solving. The primary focus is resource based because it analyzes the current resources and addresses the issue of what areas of professional development each faculty member is most interested in. The goal of this approach is to develop programs based on resources existing within the department, as well as to determine what broad shift in society's values (client needs) might require significant program changes to be made.

Ironically, this analysis of resources points to problems of theoretical differences between the models used in our own training and the models currently used in the training of marriage and family counselors. It becomes necessary then to investigate the very assumptions upon which our own training is based.

STAYING THE COURSE OR COURSE CORRECTION?

The Conundrum

As counselors or counselor educators operating in today's changing interpersonal area, depending on our age or stage or philosophical persuasion, and in some cases our economic condition, we were likely trained in one of the following therapeutic models: (1) Psychodynamic (or one of its "neo" off-shoots); (2) Behavioral (or a combination of behavioral/rational/reality); or (3) Third Force (person-centered, humanistic, existential, gestalt).

Nothing wrong with any of them. All have their time and place. Some work better in some settings, some in others. All, to one degree or another, focus on intrapsychic phenomena: what is going on within the client to make him or her dysfunctional and/or anxious?

In response to disturbing familial and societal patterns, a new category of therapeutic intervention emerged: family therapy and family systems therapy. To meet the requirements of this approach, a new training model for students seemed imperative. New programs were instituted. Nationwide, M.A. level degrees began to appear in Marriage, Family and Child Counseling. In several states, for example, licensing laws were instituted providing for an M.A. level therapist who specializes in working with families in private practice.

Now our conundrum: Is our "old" training any longer pertinent? Can we develop marriage and family counselors using our intrapsychic models of change? Is re-tooling compulsory? Must we learn the systems theories and approaches? In summary, are our backgrounds inadequate, first, to do family counseling effectively ourselves, and second, to educate our students who are inclined to do systems therapy?

THE NEW CURRICULUM: A COURSE CORRECTION

Let us first proceed as if the answers to the above do point to change, as if obsolescence in the brave new therapeutic world is a real possibility, and as if learning new models is the only way to go. What do we need to know? We shall examine our needs from four perspectives: (1) Faculty Concerns, (2) Student Concerns, (3) Therapist Concerns, and (4) Client Concerns.

Faculty Concerns

It would seem that as educators we would want to be clear about the philosophical underpinnings of family and family systems counseling. Faculty we have contacted focus on the following questions: How do families function as systems? From what core of knowledge about human collective interaction does such a theory grow? Is such a theoretical base clearly unique and free of the more classic constructs of individual human motivation and behavior? Who are the key figures in systems work?

Certainly one of the earliest spokespersons who continues to influence the practice of the family systems approach is Virginia Satir. Her Conjoint Family Therapy (1964) still stands as an appealing model of family structures, interactions, dysfunctions and interventions. More recently, Satir together with Don Jackson and Gregory Bateson, led a movement to develop family systems approaches in Palo Alto, California. Through their efforts, this "Palo Alto Group" has influenced the practice of family therapy nationwide. When considering the possibility of including such a systems approach in the training of Marriage, Family and Child Therapists, faculty must also examine the works of Ackerman (1970), Haley (1976), Laing (1972), Minuchin (1974), Bowen (1978) and Whitaker (1978).

In California, a tail-wags-dog approach to curriculum development has evolved. A State licensing board has mandated course content areas that must be covered before permission is granted to sit for the statewide examination in family therapy. Institutions whose students deserve licensing must verify to the board that they have met these designated content areas. So curriculum development is directly influenced by an outside agency.

At California State University at Northridge, that curriculum includes:

1. Human Growth and Development (social, psychological, biological)
2. Human Sexuality
3. Behavioral Disorders (psychopathology)
4. Cross-Cultural Mores and Values
5. Family Counseling (in educational and community settings); Child Counseling
6. Professional Ethics: Family Law
7. Human Communication (Practicum: Growth Groups)
8. Applied Psychotherapeutic Techniques of Marriage, Family and Child Counseling (fieldwork)
9. Research Methodology
10. Psychological Tests and Measurements

While it is apparent that these are all worthwhile areas of study for budding counselors, it is more than coincidence that this curriculum fits perfectly the ten areas required by the State Board of Behavioral Science Examiners. There are, however, indications that counselor training institutions are beginning to amalgamate and to petition the board for curricular changes, a clear reversal of the previous patterns. Some departments of counseling are calling for a greater emphasis on social psychology; and some for courses on parenting, early childhood education, and gerontology. It is clear that the more traditional curriculum--i.e., individual counseling, group counseling, personality theory, etc.--needs extensive supplementing in the new family and relationship emphases.

Student Concerns

Perhaps the most obvious student demand would be that their mentors (faculty) are current and aware of the latest concepts. Students going into family counseling must, along with their professors, know the theoretical origins and workings of family systems approaches. They must also know themselves, how they fit, how they function in a changing world.

Counselor education focused on family therapy must not ignore the development of the "self" of the new counselor. On the other hand, examination of the self as someone who has come out of and is still a member of a family system seems equally imperative. In other words, the curriculum must begin to focus on students as members of systems so that the students can identify with the family systems they will encounter.

Students are typically concerned about their internship or fieldwork. Curriculum changes may be needed to offer supervised clinical work with dysfunctional or troubled families. Some institutions would do well to explore the practicality of establishing their own community clinics.

Therapist Concerns

A major therapist concern speaks in clear tones to our training institutions. Curricular changes must consider the need for inservice programs for updating skills and theory. What faces the therapist already practicing is the icy and isolated feeling that he or she may be left behind in the explosion of new approaches and altered focus. It is already clear to many practitioners that the nature of their client concerns has changed. With chemical control of severe disorders and the increase in hospital out-patient treatment, presenting problems in private practice or in clinics have evolved more and more toward relationship problems which operate within one kind of system or another. In short, instead of practitioners facing clients with typical neurotic disorders, they are facing clients in marriage crises, in divorce, in recovery from divorce, in crises over child custody, blended families, fragmented families--primarily problems in productive communication.

Client Concerns

Whitaker and Napier, in The Family Crucible (1978, p. 294), suggest the following concerns of clients in evaluating a family therapist:

1. Is he or she strong enough to guide a family through stormy moments? (The hesitant and unsure therapist may have his/her own avoidance-of-conflict needs operating.)
2. Does the therapist seem to understand the family's dynamics?
3. Do the family members leave a session having learned something new?

4. Does the therapist seem to care about the individuals and the family as a unit?

It is clear that family therapy presents a different set of issues than does individual (intrapsychic) therapy, whether taken from a psychodynamic perspective (transference, narcissism, etc.), or a behavioral perspective (reinforcement for personal change), or a third-force perspective (self-actualization). The most profound difference is the need to educate the clients of today to begin to see themselves as members of powerful family systems and, beyond that, to see their families as parts of larger societal systems that in our present complex and quixotic world place cruel and competitive pressures upon each of its sub-units.

Perhaps counselor education curricula of the future might want to focus more on social psychology and on the myriad institutions and sub-systems in our culture. Certainly a family counselor's education would be incomplete without significant exposure to the multi-cultural nature of American society.

STAYING THE COURSE

It seems only fair now to offer some thoughts in defense of what we already know and how we already operate. Our "old" training is, of itself, not obsolete. We might do well to look at systems ideas as supplements to what we already know about the human condition, motivation, individual perceptions, and behavior, rather than replacements. Re-tooling is not the same as housecleaning. Our backgrounds are not inadequate per se. Our understanding of the dynamics of behavior (from whatever orientation) will be fine and critical cores from which to build new awarenesses about people in systems.

In fact, as counselors trained first in the intrapsychic models, we may have powerful advantages over those whose focus has been only on systems. Those advantages may lie in our commitment (to use Buber's term) to the uniqueness of the I-Thou relationship and the reluctance to see our clients too quickly as a "category" or as "one of those." Perhaps built into the nature of our one-to-one training is a salutary guard against what one might term uncalled-for systems. To decide, for example, that a family's therapy should involve one treatment rather than another may require a general diagnosis of Enmeshment rather than Detachment (Minuchin's terms), Fusion rather than Differentiation (Bowen's terms), that one is a Placator rather than a Blamer, or a Distractor rather than a Computer (Satir's terms). If we are too ready with our diagnosis, or if we fail to see that each member of a family has elements of each characteristic (and many more that defy labels), we objectify the other. We create an uncalled-for system.

CONCLUSION

Since our first task is to evaluate the resources within our institutions, we can focus on the particular needs and goals of each faculty member. Acknowledging that society demands institutional and personal flexibility, we will develop curricula that can be easily modified. So we must all take heart in the individuality and the authenticity of what each of us knows, yet remain open to the new theoretical constructs that have emerged. Our faculty, students, therapists and clients must adapt to a new societal order that mandates a new awareness, a new curriculum and new approaches that supplement our already substantial body of knowledge and strategies about human behavior.

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A Comparison of CACREP and AAMFT Requirements for Accreditation

Michele Burhard Thomas

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A COMPARISON OF CACREP AND AAMFT REQUIREMENTS FOR ACCREDITATION

According to a recent nationwide survey of counselor education programs published in Counselor Education and Supervision by Wantz, Scherman, and Hollis (1982), the most popular new area in which additional courses are being added to counselor education curricula is marriage and family counseling. The survey revealed that more than 120 new courses in marital and family therapy were either added during the past two years or were anticipated as additions in the next two years by the 445 counseling programs responding to the questionnaire. In a 25% national random sample of counselor education departments, Meadows and Hetrick (1982) found that 55% of the departments were offering one or more courses in marriage and family counseling with a trend toward increased development in this area. Such additions to traditional counselor education programs have proven to be attractive courses to students for reasons of personal growth. They have also served to prepare counselors for non-school settings such as community mental health centers and other agencies where they are called upon to do marital and family therapy as part of their job descriptions.

With the demonstrated popularity and need for marriage and family counseling courses, the possibility of a major concentration in this area becomes a viable option for curricular planners. The challenge to counselor education faculty and programs is to apply the communication skills and therapy strategies which have traditionally been taught in counselor education programs to the development of quality courses and curricula in marriage and family counseling. Nichols (1979) reported that 24 marriage and family counseling degree-granting programs at the master's level and 7 programs at the doctoral level were offered in diverse colleges and universities across the country.

At the present time, there are 14 graduate programs accredited by the American Association for Marriage and Family Therapy (AAMFT) Commission on Accreditation for Marriage and Family Therapy Education (1982). Since 1978 the Commission has been granted official recognition as an accrediting agency for clinical training and graduate degree programs in marriage and family counseling by the Office of the United States Secretary of Education (Note 1). Of the AAMFT accredited programs, only the one at East Texas State University (Note 2) is housed in a counseling department within a school of education. Piercy and Hovestadt (1980), in an article in Counselor Education and Supervision, share their process for implementation of a program accredited by the AAMFT.

Accreditation is particularly important because of its links to clinical membership in the AAMFT and to licensure for private practice as a marital and family therapist. In reviewing the current status of licensure and certification of marital and family counselors in the United States, Sporakowski and Staniszewski (1980) found that eight states had passed legislation to regulate the practice of marital and family therapy. If the trend toward expansion of licensure in the helping professions continues, there will be definite ramifications for counselors who are members of APGA. The tightening of licensing requirements by psychologists and marriage and family counselors may make it difficult for graduates of counseling programs at the master's and doctoral levels to obtain employment in the field or to advance into positions of increasing professional responsibility. Graduating from an accredited program increases the probability of an expeditious route to licensure, which may serve as a competitive edge in being hired, especially in a tight job market. Recruiting potential graduate students may become more difficult for non-accredited programs. In some states where funding cuts are being implemented in higher education, accredited programs are often assigned priority for retention on the basis of quality parameters.

Responding to such pressures, APGA formed a Licensure Commission (Kosinski, 1982). Active licensure committees were organized in 33 states. According to Kosinski (1982), Virginia, Arkansas and Alabama enacted licensure or certification laws for counselors. Thirteen other states had plans to introduce legislation in 1981.

Again the link between licensure and credentialing through accredited programs becomes evident. APGA set up the Council for Accreditation of Counseling and Related Educational Programs (CACREP). CACREP has its own accreditation manual (Note 3) with standards developed by the Association for Counselor Education and Supervision (ACES) (Note 4). Many counselor education programs are considering this process of accreditation, because of its long-range implications for improved program quality, retention of programs, enrollment, and licensure of graduates. A rational approach might be a broad view encompassing preparations for both accreditation procedures (CACREP and AAMFT) simultaneously. Changes in curriculum, support services, practicum sites and supervision arrangements could be made at the same time. This would decrease the expenditures of human energy required if each self study for accreditation was initiated separately. Invoices for new audiovisuals needed to strengthen courses could be combined with projected faculty needs.

The thrust of the present discussion is to compare areas relative to successful accreditation by both AAMFT and CACREP with a view toward combining the processes where appropriate. Points of overlap and divergence will be explored with the hope of stimulating a national dialogue concerning these issues.

INITIAL OBSERVATIONS

Some key ideas warrant attention before proceeding to the level of detailed comparisons. First, only the master's degree programs which are at least two years in length and/or doctoral studies within an appropriate doctoral degree program are eligible for accreditation by the AAMFT. As of July 1, 1982, all counselor education programs accepted for CACREP review must consist of two years (academic) of full-time graduate work or equivalent study. Therefore, both accrediting agencies stress similar lengths of study in terms of their minimal requirements for review. Many counselor education programs consisting of one year of full-time study are involved in a process of program revision to prepare for CACREP accreditation. Since a number of courses, often of an experiential nature such as practica or internships, are being added to entry-level counselor education programs to meet CACREP standards, curriculum committees may want to consider the addition of the courses in marital and family therapy required for AAMFT accreditation.

Other areas of overlap are also evident. In both accreditation schemes, there must be graduates of the program before an application can be made for review. According to both accreditation procedures, a self-study process must be initiated and a self-study report is required as part of the application process. Each accreditation manual also stipulates that students should be selected for entrance to the program on the basis of their academic qualifications as well as appropriate personality functioning.

One area of divergence relates to the supervised clinical practice requirements of the AAMFT versus the CACREP internship requirements. The AAMFT requires that the student be providing direct client services (a minimal requirement of 500 hours) for at least one and one-half calendar years (the total program except for the first academic semester), whereas an internship of 300 hours is necessary under the CACREP requirements. Part of the explanation for this lies in the divergent views of supervision. According to the AAMFT guidelines, students must receive face-to-face intense interaction from a supervisor once a week over a period of one or more years. Internship or practicum experiences which consist of only group supervision do not meet the minimum training standards of the AAMFT. The expected ratio of supervision time to client contact hours is one hour of supervision to five hours of treatment time according to the AAMFT. The CACREP standards contain no required supervision ratios for the internship experience. Supervision is performed by the staff employed by the internship setting. However, a practicum of 60 hours spaced over a minimal period of nine months is required by CACREP. One hour of one-to-one supervision and one hour of group supervision are the recommended weekly supervision minimums during the practicum. The supervision of five students in either the practicum or the internship is stated as equivalent to one course of three semester hours.

In order to meet the standards of both accrediting groups, care must be taken to exceed the requirements in both quality and quantity. Instructors of practica and internships will need to study the ramifications of the standards of both groups and suggest appropriate revisions in their own curricula. A consultant can be hired who is knowledgeable about the meaning of the experiential components of both sets of standards and who is politically aware of the subtle intricacies of both accreditation processes. Faculty committees involved in the self-study process can make recommendations to the department head concerning suggested changes in the experiential components of the programs which will meet or exceed the standards.

COMPARISON OF CURRICULA

Four of the seven curricular areas recommended by AAMFT constitute an overlap of AAMFT and CACREP standards: (1) one course in professional studies is required in which ethics, legality and other issues of professional role and responsibility are covered; (2) one course in methods of research (AAMFT stresses studies in the marital and family therapy field); (3) one elective course for which any counseling course would suffice; (4) two to four courses in individual development (such as advanced developmental psychology, abnormal psychology, theories of personality and courses in human sexuality). Most of the aforementioned courses are often included in counseling programs, especially those at the doctoral level.

In addition, a minimum of one year or nine semester hours or twelve quarter hours of supervised clinical practice is required by the AAMFT standards. Working about half time, students deliver 500 hours of direct services to clients in supervised clinical practice. Almost all doctoral programs in counseling offer appropriate practicum experiences, as do many counseling programs at the master's level. The CACREP accreditation standards require both practicum and internship experiences at the master's level and a full-time internship as part of a doctoral program. At the master's level, the minimum amount of client contact time in the practicum is 60 clock hours during the academic year, while the intern is required to spend at least 300 clock hours on the job. At the doctoral level, a full-time internship of 36 weeks is recommended by CACREP, including the internship experience provided in the master's program.

The curricular areas which are most divergent from traditional counselor education programs are those of marital and family systems, and marital and family therapy. Six to twelve semester hours of coursework in marital and family systems and six to twelve semester hours of coursework in marital and family therapy are required by the AAMFT, with a total of 27 semester hours or 36 quarter hours required in a combination of marital and family systems, marital and family therapy, and individual development.

The systems orientation to intervention is included within the rubric of marital and family systems. Students are exposed to individual, sibling and marital subsystems of the nuclear family. Family sociology may be an excellent source of materials for such coursework. The study of healthy families, the student's family of origin, alternative family structures and family simulations are typically contained in a systems approach to clinical work in marriage and family counseling.

The major theoretical approaches to counseling work with couples and families, such as behavioral, psychodynamic, experiential, strategic, communications and structural, are included within the area of marital and family therapy. Students are encouraged to use a range of therapy modalities including individual, conjoint marital, conjoint family, concurrent, marital group and other treatment structures. In this way, students learn to deal flexibly with diverse configurations of clients in the treatment room, from individuals to couples to families to groups of couples. Ways of effecting systems change are emphasized within the various therapy modalities.

FACULTY QUALIFICATIONS

The administrator of the clinical portion of an AAMFT marriage and family counseling program must meet the minimal standards of the AAMFT for the clinical practice and supervision of marital and family therapy. A total of three professional marital and family therapists must supervise the clinical practice of students. Not all of these professionals must be hired as full-time employees by the university. At least some of the senior staff must have credentials equal to the criteria for clinical membership in the AAMFT. According to Kosinski (1982), the requirements for membership in the AAMFT by allied mental health professionals such as counselors will increase after December 31, 1983 (Note 5). In order to become clinical members of the AAMFT at the present time, counselor education faculty holding the doctoral degree in counseling or a related area typically may be asked to complete two courses in marital and family systems and one course in marital and family therapy, if they have completed the appropriate clinical experiences in practica and internships as part of the work toward their doctoral degrees.

FUTURE TRENDS

One advantage of implementing a concentration in marital and family therapy as part of a master's or doctoral degree-granting counseling program is the attraction of a new constituency. Many ministers, religious educators, social workers and mental health counselors are interested in improving their counseling skills in working with married couples and families. In addition, a number of students may take courses or minors in marriage and family counseling for personal growth and development. Some of these students may decide to pursue master's or doctoral degrees as a by-product of such outreach or feeder courses. With the divorce rate increasing yearly in the United States and the expanded expectations for marriage to fulfill spouses' needs for intimacy, dependency, sexuality, intellectual dialogue, parenting and companionship, it is no wonder that courses in marriage and family counseling are in demand.

The state of transition affecting counselor education programs across the country at the present time provides an innovative atmosphere in which counseling programs can be creatively improved. In setting goals of involvement in the accreditation processes of both CACREP and AAMFT, department heads and faculty in counselor education can lead the way to a higher level of instruction and service delivery. The future will be what we make of the present—strong programs which meet the needs of an ever-increasing diversity of students who will deliver quality services to individuals, married couples and families.

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Integrating Marriage and Family Therapy Within Counselor Education: A Three-Level Model

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INTEGRATING MARRIAGE AND FAMILY THERAPY WITHIN COUNSELOR EDUCATION: A THREE-LEVEL MODEL

INTRODUCTION

Counselor education programs are rapidly expanding in the number and types of courses and clinical training offered in marriage and family therapy (MFT). This chapter describes a three-level model for the integration of marriage and family therapy within counselor education. A description of each of the three levels follows.

Level One: MFT Degree or Degree Equivalent

Level One denotes marriage and family therapy as a mental health profession with a corresponding MFT degree or degree equivalent program as the requirement for practice. A "degree equivalent program" is defined as a department or program that awards a degree other than one titled marriage and family therapy. The degree equivalent program, in *all* other respects, meets nationally established curricular requirements for the MFT degree.

At this time, several governmental agencies respond to or officially recognize MFT as a profession. These include: Office of the U.S. Secretary of Education; U.S. Department of Health and Human Services; U.S. Department of Defense/CHAMPUS; and National Institute of Mental Health. Several states have granted statutory recognition (licensure or certification) of MFT as a mental health profession.

Level Two: MFT Concentration

Level Two denotes marriage and family therapy as a concentration within the structure of its respective degree program. Thus, an MFT concentration is a program of limited scope and planned sequential study, complementing and adding to the professional core curriculum of the degree. Examples of Level Two training occur within degree-granting programs, such as psychiatry, family medicine, psychology, counseling and guidance, clinical social work, pastoral counseling, and applied family studies.

Level Three: MFT Elective Study

Level Three indicates an ad hoc study of MFT through activities such as elective graduate courses, continuing education programs, and/or in-service training. This sort of study broadens the theoretical and conceptual base for counselors preparing to work in a preventive role; e.g., with the developmental problems of healthy families. Knox (1981) proposes seven limited objectives for increasing counselors' awareness and understanding of marriage and family issues. These objectives are appropriate for Level Three training.

MFT PROGRAM COMPONENTS

The aforementioned three levels of MFT education broadly identify basic goals and objectives for the degree or degree equivalent, concentration, and elective study. Each level, in turn, requires a certain level of appropriate curriculum and supervised clinical training.

Curriculum

Level One

The content of an MFT degree or degree equivalent program is specified within the following model curriculum developed by the Commission on Accreditation for Marriage and Family Therapy Education. All components of this model are essential to a comprehensive marriage and family therapy curriculum at either the master's or doctoral level (*Marriage and Family Therapy: Manual on Accreditation*, 1981). The components of this curriculum are listed in Table 1 (p. 34).

The information presented in Table 1 requires some elaboration. The marital and family systems area of study develops an understanding of the systemic approach to therapeutic intervention. The student learns to conceptualize family interaction through integration of systems theory, family sub-systems and family development.

An examination of the nuclear family, its numerous derivatives, and family of origin theory are important components of this area of study.

The marital and family therapy area of study is designed to develop an in-depth understanding of major theories of system change and systemic intervention techniques. The major theories studied in this content area are strategic, structural, communications, behavioral, experiential, and neo-analytic therapies.

In the area of individual development the following content is included: human development, personality theory, behavior pathology, and human sexuality. The Professional Studies area includes content concerning: (a) the role and function of the professional marital and family therapist; (b) issues regarding professional licensure/certification; (c) professional ethics; (d) family law; and (e) issues regarding independent practice as a marital and family therapist. The research area of study at the degree level includes information about research design and statistics while maintaining a primary focus on research in marital and family therapy and studies. The supervised clinical practice area of training includes intensive supervised therapy with couples and families. This area is described in detail in a later section of this chapter (Marriage and Family Therapy: Manual on Accreditation, 1981; Winkle, Piercy, & Hovestadt, 1981).

The areas of study for a Level One training program may be varied. Therefore, colleges and universities seeking to develop a program at this level may need to integrate course offerings from several departments within their institution (Piercy & Hovestadt, 1980).

Level Two

Curriculum at the MFT concentration level commonly includes a limited number of sequenced and planned courses and clinical experiences identified as areas of study within Table 1. Within the areas of marital and family "systems" and "therapy" fewer courses are offered and required than at Level One. Individual development as an area of study is very similar at Levels One and Two with respect to both the content and number of required courses. Professional studies at Level One generally focus on specific ethical, legal and professional issues in family therapy, while professional studies at the concentration level weigh course content more heavily toward individually oriented issues in counseling.

Table I
Model Curriculum

Area of Study		Sem Hrs	Qtr Hrs
1. Marital and Family Systems	2-4 courses	6-12*	8-16**
2. Marital and Family Therapy	2-4 courses	6-12*	8-16**
3. Individual Development	2-4 courses	6-12*	8-16**
4. Professional Studies	1 course	3	4
5. Supervised Clinical Practice	1 year	9	12
6. Research	1 course	3	4
7. Electives	1 course	3	4
		45	60

* 27 Hr Minimum in total of areas 1, 2, 3.
** 36 Hr Minimum in total of areas 1, 2, 3.

Supervised clinical practice at both Levels One and Two requires a practicum of at least one year in duration. At the Level Two concentration the student would be required to log a number of marital and family therapy cases within the broader context of a client caseload involving individual counseling and/or group counseling. Research as an area of study at the concentration level is typically undifferentiated in nature and broadly encompasses the parameters of research in the social sciences. No concrete observations can be made with respect to electives at a concentration level. It may be noted, however, that at Level One, electives commonly involve advanced coursework in either individual and/or group psychotherapy.

The marriage and family therapy training provided at Level Two of the model should prepare the counselor to work with many families and couples. This level of training should provide the counselor with sufficient theoretical and clinical expertise to competently evaluate and treat a wide variety of marital and family problem situations. When the counselor's assessment indicates that the family or couples are more resistive, exhibit intense systemic dysfunction, or do not respond to therapeutic interventions, the counselor may refer to a professional marriage and family therapist with educational and clinical training at Level One.

Level Three

Curriculum at the MFT elective level is offered on an ad hoc basis to students who seek to broaden their theoretical and conceptual framework for helping. These courses frequently meet a specific and immediate continuing education or in-service training need for the student and are viewed as augmentation to their individual and group oriented therapeutic training. The MFT elective level is distinguished from the MFT concentration level in that the elective level is not a planned sequence of MFT study and includes fewer courses than the MFT concentration.

The MFT elective level of training would typically include an introduction to MFT and marital and family systems in a single combined course. In addition, Level Three training occasionally offers coursework in areas related to parent education. Individual development is generally well-covered by the requirements of the core degree program. Professional studies at Level Three are similar to those at Level Two in that a specific focus on marital and family therapy issues may be a single component of the course, if present at all.

In the supervised clinical practice area of curriculum, the Level Three program generally makes no specific provisions for supervision of marital and family therapy from a systemic base. While couples and families may occasionally be seen in the practicum, intervention generally focuses on individually-oriented developmental concerns or life crises for specific members within the family. Professional training in the research area for Level Three is congruent with that provided at Level Two.

Counselors trained at Level Three will be frequently qualified to provide educational and preventive services to couples and families, such as parent education, pre-marital education/counseling, and marriage enrichment. This level of training also provides the counselor with the skills necessary to identify marital and family problems that are not changed through educationally-based interventions and to prepare these clients for a successful referral to a Level Two Counselor or Level One Marriage and Family Therapist.

Because marital and family problems are so widespread, most counselors in public or private settings will have the opportunity to work with couples and families. Ethical considerations dictate that all counselors work within the boundaries of their expertise.

Supervised Clinical Practice

Level One

The following clinical training model illustrates a program of supervised clinical practice at the degree or degree equivalent level of MFT education (Piercy, Hovestadt, Fenell, Franklin, & McKeon, 1982). Most components of this three-phased model were developed at East Texas State University with funding assistance from the National Institute of Mental Health (Grant #MH 16608). The components of this three-phased model are discussed below.

A. The Immersion Experience.

The immersion experience is an intensively supervised internship in family therapy with individuals, couples and families. This internship takes place at the on-campus Marriage and Family Therapy Center. Trainees enter the immersion experience at the "developing clinician stage" (see Figure 1, p. 38). This designation implies that the student has previously gained necessary generalist skills in psychotherapy.

The supervision provided during the developing clinician stage is based on structural family therapy (Minuchin, 1976; Minuchin & Fishman, 1981). The structural family therapy model was chosen because it (a) is straightforward and direct; (b) is relatively easy to understand for the beginning marital and family therapist; and (c) has demonstrated utility (Stanton, 1981). As trainees become proficient in conceptualizing and intervening from a structural theoretical orientation, supervision expands to include other theories of marital and family therapy.

A team approach to live supervision is employed throughout the developing clinician stage. This type of supervision involves a supervisor and small group of students observing each developing clinician conducting therapy (Coppersmith, 1980). At the conclusion of the therapy session, the clinician receives feedback from the supervisor and team members. The team views its responsibilities as facilitating the developing clinician's ability to (a) conceptualize the case from a structural family systems approach; (b) develop a tentative treatment strategy based on family structure, and/or external societal systems; and (c) select and employ appropriate techniques to carry out the treatment strategy.

When the student demonstrates competence in structural family therapy he/she enters the "marital and family therapist stage" of the immersion experience. During this stage the trainee is supervised on a less frequent basis, usually one hour of individual and two hours of small group supervision per week. The trainee presents audio or video tapes of his/her therapy with particularly difficult cases. Thus, in this stage there is a shift to a delayed consultative supervision (vis a vis live supervision) which allows the trainee to be more autonomous in his/her work with clients. This more traditional supervision is designed to prepare the trainee for the next phase of the program which is an externship placement (Piercy et al., 1982).

B. The Externship Experience.

During this second phase of the training program, the trainee is placed in a mental health agency where his/her caseload primarily involves marital and family therapy. The trainee continues to receive weekly on-campus supervision and consultation. Additionally, a faculty supervisor or field consultant (described below) periodically visits the trainee on site. The externship experience normally extends from five to nine months.

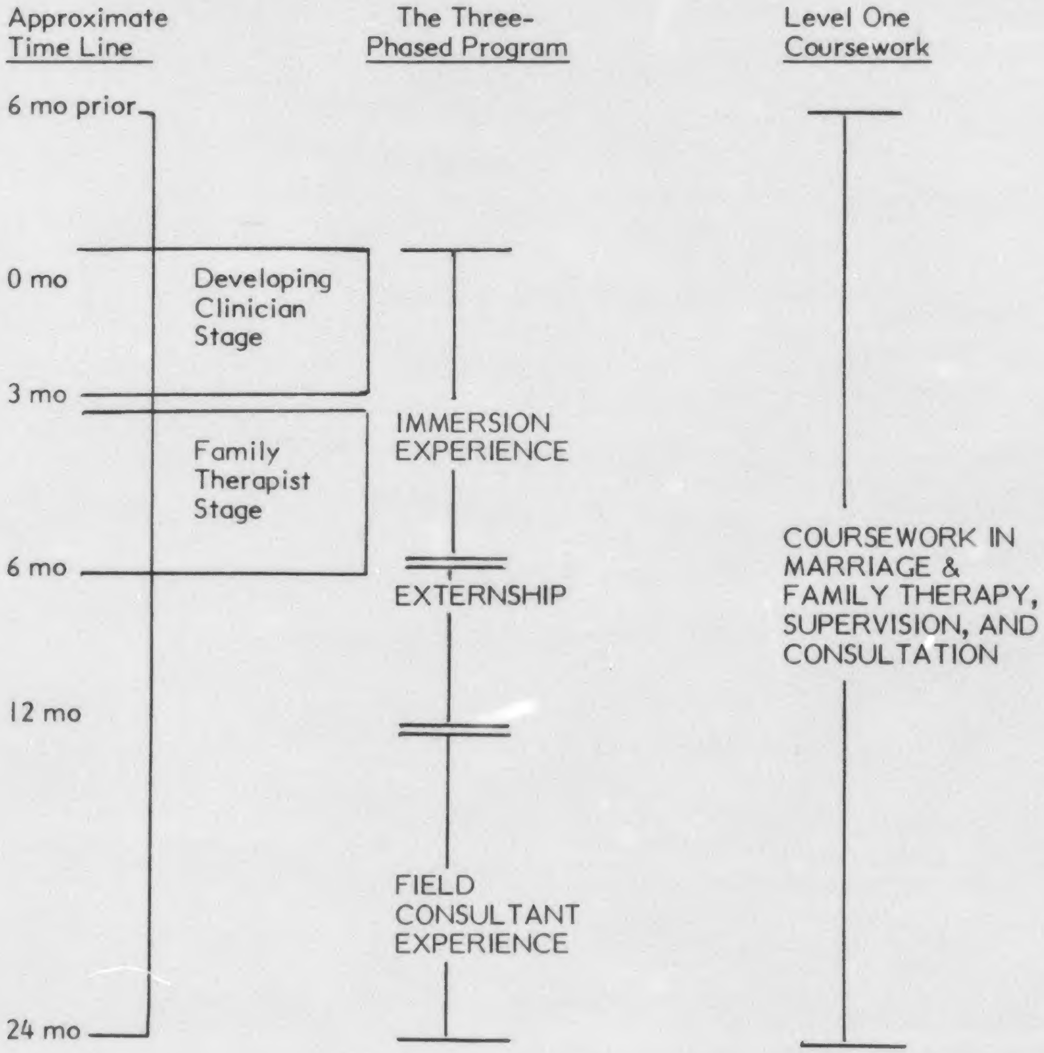
C. The Field Consultant Experience.

After completion of the externship, selected trainees are invited to participate in the third phase of the training program, the field consultant experience. Those selected for this phase of the training program must have (a) indicated an interest in participating; (b) completed the doctoral-level course covering the supervision of family therapy; (c) developed advanced marital and family therapy skills; and (d) demonstrated an in-depth understanding of systems concepts, family of origin and external societal influences. The field consultants, under the close supervision of MFT faculty with senior academic and clinical standing, are assigned the responsibility of supervising and consulting with the students in both the immersion and externship phases of the training program (Piercy et al., 1982).

Several other models of Level One supervised clinical practice are in operation at institutions such as Brigham Young University, Purdue University, Texas Tech University, and the University of Southern California.

Figure 1

Schematic of Marital and Family Therapist Training Program


Approximate Time Line
The Three-Phased Program
Level One Coursework
6 mo prior
0 mo
3 mo
6 mo
12 mo
24 mo
Developing Clinician Stage
Family Therapist Stage
IMMERSION EXPERIENCE
EXTERNSHIP
FIELD CONSULTANT EXPERIENCE
COURSEWORK IN MARRIAGE & FAMILY THERAPY, SUPERVISION, AND CONSULTATION

Level Two

Supervised clinical practice within a Level Two MFT concentration involves the planned inclusion of a limited number of clients presenting a variety of concerns or problems regarding marital and/or family issues. This MFT clinical experience occurs within the context of a general counseling practicum or internship. Those cases involving marital and family related issues will be supervised by an academically and clinically qualified MFT supervisor.

Contrasting Level One and Level Two internship programs, it should be noted that most Level One programs offer their MFT clinical training block within a specifically designed MFT training center. These training centers are viewed as an integral part of the operation of the MFT program and usually have three objectives: (1) MFT training; (2) MFT research; and (3) community service.

Level Three

Clinical practice at the MFT elective level of study does not include a planned sequence for skill development in marital and family therapy. Occasional clients presenting marital or family issues are responded to by employing educational and developmentally oriented strategies to promote change and growth. When the presenting issues are not ameliorated through the counselor's intervention, the Level Three trained counselor has the knowledge and skills in MFT to effect an appropriate and successful referral to either a Level Two counselor or Level One marital and family therapist.

PROFESSIONAL ISSUES RELATED TO INTEGRATION

Dual Professional Affiliation

Piercy and Hovestadt (1980), in their commentary on dual professional affiliation, note that the American Personnel and Guidance Association (APGA) and the Association for Counselor Education and Supervision (ACES) have for many years lent professional support to a wide range of human services. Interest in MFT has also led many counselor education departments to become increasingly involved with the

American Association for Marriage and Family Therapy (AAMFT), founded in 1942, as the association for the field of marriage and family therapy. This 11,000 member association sets credentialing standards for the practice of marriage and family therapy centers and supports state and regional marriage and family therapy affiliate associations. Through a comprehensive application procedure, East Texas State University became the first counselor education program to be acredited by AAMFT as a doctoral degree-equivalent-granting institution for marriage and family therapy education. Because the Office of the U. S. Secretary of Education in 1978 recognized AAMFT's Commission on Accreditation for Marriage and Family Therapy Education as the national accrediting agency for MFT, and because there are now approximately 11 accredited academic MFT programs, AAMFT accreditation represents distinct advantages in recruitment, publicity, and professional recognition.

If students in degree and concentration programs are to become well-rounded MFT professionals, MFT educators must make themselves an integral part of the professional support systems within APGA and AAMFT. Faculty and students may maintain dual professional affiliation through publications, convention presentations, and the occupation of state and national offices (Piercy & Hovestadt, 1980).

The Politics of Integration

The first and perhaps overriding issue pertaining to any level of integration of MFT education is whether there is sufficient faculty support present to establish and maintain that program at a particular training level. Successful integration requires the support of an entire faculty.

Liddle and Halpin (1978), in their review of marital and family therapy training and supervision, report that counselor education programs which operate from a primarily intrapsychic orientation frequently resist acceptance of an interpersonal/systemic definition of human problems. Further, these authors note that in some instances students feel pulled between faculty supporting divergent philosophies. Additionally, MFT education faculty may feel isolated from their colleagues.

IS MFT FOR YOU?

What seems clear is that before any concrete steps are made toward any level of integration of MFT education within Counselor Education, departmental responses to the following questions should be sought.

(a) Do the advantages of beginning a new program that may attract additional students outweigh the possible disadvantages?

(b) Are sufficient qualified faculty and physical resources available to support the program at the level desired?

(c) Does a sufficient reservoir of faculty goodwill exist to resolve the issues that will inevitably arise from concurrently offering programs with intrapsychic and interpersonal/systemic philosophies?

CONCLUSION

Counselor education departments have begun to seriously consider the integration of marriage and family therapy into their training programs. This article has proposed three levels of integration of MFT that may be adopted. Varying degrees of resources and commitment are required to implement these levels. Level One will require a very high commitment, Level Two will require a lesser but still significant commitment, and Level Three will require the least commitment in professional personnel and fiscal resources. Each counselor education department is encouraged to carefully weigh the advantages and disadvantages of integrating marital and family therapy into their program.

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Gender Issues of Family Systems Therapists

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GENDER ISSUES OF FAMILY SYSTEMS THERAPISTS

This article discusses the male/female gender issues that are both implicit and explicit in the training of students in family systems therapy and the practice of family systems therapy. The major aspects are: (1) males and females tend to view the same situation from different perspectives which can be attributed to biological and socialization variables as well as to different childhood experiences in relating to parents; (2) gender issues are inevitable in processes of family systems therapy and supervision, and these require primary consideration in establishing and implementing the training curriculum; (3) there are individual differences within genders and between genders as well as generational differences; (4) family systems therapists with high levels of androgyny can be sensitive to the intrinsic and extrinsic gender issues of client family systems.

Whether male or female, there are gaps between what therapists say they believe, their "espoused theories," and what they actually practice, their "theories of use," regarding emotionally laden gender issues. Perhaps one of the reasons that these issues are so emotionally laden is that they are so intertwined with our primary relationship to same-sex and opposite-sex parents in our families of origin. In any case, most therapists are unaware of the gaps between their "espoused theories" and "theories of use"; they believe that their therapy training and practice is gender free and sex fair. Nevertheless, if supervisors are not truly aware of and sensitive to gender issues, supervisees may never have to acknowledge these issues, much less deal with them.

Male and female supervisors who have consciously worked to understand their own gender issues and to achieve some level of androgyny are more likely to notice these gaps in their supervisees' experience. Supervisors who understand these issues are also more likely to bring an awareness into supervisory sessions as an important focus than supervisors who ignore or devalue the existence of gender issues. A recent study by Yoger and Shadish (1982) found that even androgynous females, who see themselves as relatively free from sex-role limitations, still behave as therapists in accordance with traditional gender expectations.

Sex-role issues are likely to surface more dramatically in family systems therapy than in individual therapy. Perhaps this difference is due to the interactional focus and the likelihood of representation by both genders in family systems. At the same time, working with family systems reconnects the therapist with his or her own family of origin and the basic attitudes, expectations and behaviors learned and fostered in early life. Equally important, client families have their own sex-role expectations of the therapist. These may or may not coincide with those of the therapist's own family of origin and the family systems therapist may find him or herself unwittingly inducted into the client family system's paradigm.

The American Psychological Association (APA) Task Force on Sex Bias and Sex Role Stereotyping (1975) found family therapists particularly susceptible to the following sex-role biases: (1) assuming that remaining in a marriage would result in better adjustment for the woman; (2) demonstrating less interest in or sensitivity to a woman's career than a man's career; (3) perpetuating the belief that child rearing and the child's problems are primarily the mother's responsibility; (4) exhibiting a double standard for a wife's versus a husband's extramarital affair; (5) deferring to the husband's needs over those of the wife. Other studies (Margolin, 1982; Gurman & Klein, 1981; Hare-Mustin, 1978) also conclude that there is a tendency of marital and family therapists to reinforce sex-role stereotyping.

Chodorow (1974) suggests that males and females have developed basic sex differences in personality due to the different ways they experienced their primary parent, mother, in childhood. Since both males and females are primarily parented by a female parent, there are differences in the way this female parent responds to and socializes her same-sex offspring than her opposite-sex offspring. It is this primary relationship that establishes the therapist's "theory of use" unless conscious attention has been paid to integration with current learnings. The therapist's "theory of use" is more influential than his or her "espoused theory" on assessment, formulation of goals, and interventions for client families because it is the theory which determines actual therapist behaviors.

Competence in family systems therapy requires different skills and a different kind of role flexibility than most forms of individual therapy. The structural and strategic approaches to family systems therapy require the use of directive skills, a shift from reliance on the therapeutic relationship characteristic of individual therapy to reliance on task-related interventions and active expression of authority and competence on the part of the family systems therapist. These skills are difficult for females because they are unfamiliar to their warm, nurturing, relational behaviors in their sex-role experience. Likewise, males find nurturing, relational behaviors unfamiliar and antithetical to their task-related, achievement behaviors in the sex-role experience.

GENDER DIFFERENCES

The sociological and psychological literature (primarily male in authorship and subject) posits divisions along lines of gender as to how people define themselves, their salient qualities, their goals, their modes of making choices and their styles of relating. The terms "instrumentality" and "expressiveness" were coined by Parsons and Bales (1953) who defined the appropriateness of males behaving in achieving, competitive, logical, world-oriented ways (instrumental) and females functioning in the area of affiliation, as mediators of family values and well-being (expressive). Instrumental qualities are, then, masculine as men are viewed as the primary wage earners and protectors of the family from outside forces. Expressive functions are feminine, as women nurture children and keep the emotional component of the family intact. These notions form the basis for sex-role expectations in any relationship system, whether it be a family, a work organization or a community organization: men are expected to be powerful, directive, cognitive, task-oriented; women are expected to be nurturing, indirect and accommodating. Men are praised for aggressive behavior; women are castigated for the same behaviors.

The aspect of nurturant empathy in the therapist role is parallel to the expressive sex-role stereotypes of females. The aspect of active, objective interpretation parallels the authoritative instrumental sex-role stereotypes of males. Since the practice of family systems therapy requires strategies that are instrumental as well as expressive, each gender has some unfamiliar behaviors to learn.

The concept of androgyny is relatively new. This concept posits that males and females possess both expressive and instrumental competences. These traits and competences are "different but equal" (Gilligan, 1982). A full complement of both instrumental and expressive modes of perceiving and behaving is valuable and, in fact, necessary for all people who aspire to be fully dimensioned.

All of which cannot obviate that gender differences do exist and are, most likely, both biologically and culturally determined. The tensions between instrumental/expressive (Parson & Bales, 1953), anima/animus (Jung, 1933), affiliation/achievement (McClelland, 1975), inclusion/separation (Kegan, 1982), agency/communion (Bakan, 1966) are basic to human experience and do not need to result in "either-or" choices. As Langdale (1980) points out, it is important not to be caught in the trap of denying sex differences (usually out of the mistaken belief that maleness provides the norms) but to focus on the full human potential and development of both genders.

In the past decade, there have been a few articles in the professional journals devoted to sex-role issues affecting the supervision of counseling/therapy students and its practice (Abramowitz & Abramowitz, 1976; Berger, 1979; Broverman, Broverman, Clarkson, Rosenkrantz, & Vogel, 1970; Caust, Libow, & Raskin, 1981; Chesler, 1972; Fabrikant, 1974; Gershenson & Cohen, 1978; Gurman & Klein, 1981; Hare-Mustin, 1978; Rice & Rice, 1977; Yoger & Shadish, 1982). These relatively few articles have, for the most part, focused on the gender issues inherent between male supervisors or therapists and female students or clients. There is a noticeable lack of any discussion of the effects of female supervisors and therapists on male students and clients.

The following discussions of specific gender issues affecting female and male family systems therapists are based on this limited literature, my own supervisory and clinical experience, and years of discussions with colleagues, students and professional associates.

GENDER ISSUES FOR WOMEN FAMILY SYSTEMS THERAPISTS

A major issue for women family systems therapists is to learn to function comfortably and effectively in an active, directive, powerful manner--to behave more instrumentally. This type of role flexibility is unfamiliar to most women's background. They lack the experience of directly influencing clients and expressing competence, expertise and power assertively. Women have been socialized to be self-deprecating and to fear their success or competence, to go to great lengths to appear to be pleasing and accommodating while covering up evidence of their expertise. They have also been trained to avoid rejection, particularly by males. If a woman is successful and competent, she will be a threat to men who will, in turn, reject her.

Women, therefore, need to learn to take risks, to confront men and other authority figures constructively and effectively. They need to learn to engage in rapid decision making and task assigning and to be able to control and move people around. Women need to learn to behave instrumentally without abandoning their natural warm, empathic, nurturing behaviors. One of the reasons that this is difficult for women is their lack of encouragement and permission to achieve sufficient self-differentiation so as not to be dependent upon others, particularly men, for affirmation and approval. Chodorow (1978) points out that women never completely differentiate from their primary relationship with their mother, whereas men are encouraged to individuate from early childhood. Thus, self-differentiation is the norm for men and a deviation for women.

With a lack of experience in instrumental behaviors, power and conflict may be important issues for many women. Since they have learned to avoid direct confrontation and to downplay authority, they function more comfortably with covert power strategies (denying, of course, that they have any interest in or desire for power) than with outright power moves. This result may be manifested by female therapists avoiding the confrontation of dominant fathers or acting-out male adolescents during therapy.

Boundary issues may also present difficulty for women therapists whose own boundaries are more permeable than those of male therapists. Women's friendships are likely to be more numerous and intimate than mens' friendships. And women's family and occupational lives are more likely to overlap. Men, on the other hand, are more familiar with boundary compartmentalization, while women may feel more comfortable with inclusion, rather than separation.

Joining the family system is not usually a problem for female therapists. However, lacking experience as leaders, they are often reluctant to join a system assertively, as an initiator rather than as a follower or opposer.

Women may experience some difficulty in achieving a symmetrical relationship with the father. They often readily join with young children. And, depending on their own life stage and experience, they are relatively comfortable with adolescents. Their own history as a daughter will influence how they join with the mother in the system. They may empathetically identify with her and show support and caring or, on the other hand, they may exhibit patronizing attitudes towards "conventional" women and ally with the father against the weaker, more ineffective wife. This situation may reflect their triangulated role in their own family of origin.

Women trainees often report that they are reluctant to deal with marital issues in conjoint family therapy, preferring to focus on parenting issues. They feel more secure dealing with parenting, a primarily feminine role, and uncomfortable dealing with the sexual and power aspects of the couple system. It is difficult for women to be assertive and confrontive in a paternalistic system, whether a client family or an educational institution.

As the field of family systems therapy has been dominated by male theorists and supervisors, female therapists do not have sufficient role models to teach them instrumental strategies that do not obliterate expressive qualities. Female therapists who model themselves after Virginia Satir are choosing a more feminine, traditional approach to family systems therapy. Many female therapists are uncomfortable with the more powerful strategic and structural approaches of Haley, Minuchin and Bowen so they fall back on the communications strategies which are less directive and more empathic. Some powerful structural and strategic female therapists are now beginning to gain prominence as influential family systems therapists. These include Peggy Papp, Chloe Madanes, Betty Carter, Marianne Walters, Olga Silverstein and Marie Selvini-Palazzoli. Female and male trainees who have been exposed to these therapists are amazed at their demonstration of an integrated, effective use of instrumental and expressive behaviors.

The supervisory relationship is, by its nature, evaluative and can be threatening. Women are used to behaving in stereotypical submissive ways to paternalistic male authority figures. They may repress their anger and avoid conflict by accommodating his implicit and explicit role expectations. Perhaps the female supervisee will relate seductively to her male supervisor, flattering his ego so as to achieve her own ends (a positive evaluation and acceptance into a male-dominated profession). Or she may risk opposing behavior and jeopardize her professional future by becoming stuck in power struggles with authority figures. Since her relationship with her supervisor will impact her professional future, she will be unlikely to risk androgynous behaviors as a therapist if this is contrary to her supervisor's values and expectations.

By the same token, Chadbourne (1980) reports that female trainees often avoid female supervisors or mentors because they are not seen as having sufficient power to protect and open doors for their supervisees. In other words, females and males both perceive female supervisors as being on the fringe of the male power structure of the training organization. With male supervisors, females are, as stated earlier, likely to adopt traditionally submissive roles. Many female supervisees perceive that they are undervalued and, as a result, evaluated lower on competence bases than their male counterparts by both male and female supervisors. Female supervisors may be dealing with the same male power structure of their organization and, therefore, attend more favorably to male supervisees than to female supervisees in order to gain their male colleagues' approval. Thus, the female underling may try even harder to gain her male supervisor's approval by more compliant behavior, believing that she has a higher likelihood of success with a male supervisor than with a female supervisor.

GENDER ISSUES FOR MALE FAMILY SYSTEMS THERAPISTS

Just as the female therapist's behaviors with male supervisors and clients reflect her own gender issues based on her relationship with her mother and father, the male therapist's behaviors with a female supervisor or client reflect his gender issues based on his relationship with his mother and father. Having been primarily raised by an opposite-sex parent, men have different identification and intimacy issues than do women, who were raised by a same-sex parent. Daughters are encouraged to remain attached whereas sons are encouraged to separate and individuate. Men may experience a tension between their need to receive nurturing and valuing from women and their need to exhibit strong, self-sufficient behaviors like their more distant father. Therefore, whereas women family therapists are naturally more comfortable with the affect and relationships of the family system, male family therapists are more naturally inclined to focus on the power structure and content issues. They are naturally inclined to instrumental behaviors which prepare them for structural and strategic interventions in family systems therapy.

Men often fear engulfment by adult females. This fear will affect their relationships with female supervisors as well as with the mother in the family system. With families, they may ally with the father and overvalue his position. They may ignore the mother or they may be overprotective of her, idealizing her femininity. Either way indicates an underlying belief that mother is not as strong or as competent as father.

Men often have difficulty in joining the family system with affect. They are more likely to focus on cognitive content than affective process, preferring the concrete problem-solving of the symptomatic behavior than a sorting-out of the underlying relationship processes. The male therapist is often perceived as powerful and expert from the initiation of contact with the client family. He enters the system with power credibility, whereas the female therapist has to struggle to gain credibility with the client system. This role may result because the mother of the family is often the initiator of therapy and automatically ascribes status and authority to the male therapist. The male therapist needs to learn to attune himself more sensitively to the affective qualities of the family and to feel comfortable utilizing and modeling nurturing, empathic behaviors to family members. He needs to learn to relate symmetrically to both the mother and the father.

Male trainees seem to focus more on couple system issues and less on parenting issues with children and adolescents. They often appear to be impatient with the emotional aspects of parenting and are more comfortable dealing with the sexual and power aspects of the couple system. They also tend to value the father's occupational role more highly than the mother's and automatically assume that the mother has primary parenting responsibility.

GENDER ISSUES AFFECTING MALE AND FEMALE FAMILY SYSTEMS THERAPISTS

It becomes clear that both male and female family therapists have need to develop integrated attitudes and behaviors reflecting both instrumental and expressive dimensions. This will diminish the discrepancy that occurs in family assessment. Female therapists, for example, tend to focus on different issues and to view dysfunction differently than male counterparts. They may be less likely to label the woman's behavior as "disturbed" or "problematic" because, having lived their lives as "second class citizens," they may be naturally sensitive to the underdog in the family system. Whom therapists depict as the "bad guy" in the family system often is a direct reflection of their gender issues.

Male family therapists may be more uncomfortable with nonstereotypic behaviors and covertly encourage the stereotypical status quo of the family system. Their life experiences may not have forced them to consider or adopt nonstereotypic roles and behaviors. Women therapists are often nonstereotypical by virtue of their choice of professional role. A woman therapist may be more alert to women's career issues and she may be more sensitive to and responsive to those issues than a male therapist.

The issue of sexuality cannot be ignored, even though it is difficult to document and most professionals prefer not to address it. Certainly, there are many reported incidents of female clients and supervisees being sexually harassed by male therapists and supervisors. There are also reported cases where male clients or supervisees have been sexually harassed by female therapists or supervisors. Somehow, the latter cases are not taken seriously by either male or female professionals, and the former cases are only taken seriously as a result of arduous efforts by the women's movement. Sexual harassment is exploitation regardless of which sex is sexually harassing the same or opposite sex, and it must be dealt with assertively.

Whereas women therapists often relate to male supervisors and clients in either traditionally submissive ways or as seductive little girls, male therapists and supervisees often relate to their supervisors and clients of the opposite sex as somewhat patronizing "buddies" or as seductive little boys. Both male and female supervisees who adopt seductive strategies are seeking to manipulate their supervisor in nurturing and approving evaluative behaviors.

Male supervisees often find it difficult to accept and value feedback from a female supervisor. This reflects their basic undervaluing of women as well as their need for approving, nurturing caretaking. And some female supervisors, in order to compensate for their feelings of inferiority within the power structure, play right into this situation. Like their male counterparts or the "queen bees" that Kanter (1976) cites, they, too, overvalue male supervisees and undervalue female supervisees.

CONCLUDING COMMENTS

The point of this article is to call attention to the importance of gender issues in training and supervising both male and female family systems therapists. Whereas gender issues are pervasive in any interactional context, they appear to be particularly potent within family systems. Therefore, all family systems therapy trainees and practitioners need to acknowledge and consider their own attitudes, values and beliefs and how these translate into their behaviors as therapists. How do they perceive and relate to male family members? to female family members? Are there differences in the way they assess and intervene with males and with females?

Gender differences do not account for all interpersonal difficulties. Obviously, there are wide ranges of stereotypic and androgynous behaviors within each gender and between gender groups. Some male therapists are more "feminist" in outlook and behavior than some female therapists. In addition to these individual differences, there are ethnic and idiosyncratic family-of-origin themes which have covert as well as overt implications for the family systems therapist. Some ethnic heritages foster more traditional sex-role stereotypes than others, and often one is not aware of the pervasive influences of one's ethnic background. To deal with these implications, it is imperative to acknowledge the existence of gender issues in supervisory and therapeutic processes.

It is not necessary that family systems therapists impose androgynous values on client family systems. However, more androgynous therapists can be effective in increasing the range of role flexibility and options for client families by means of teaching and educating and by means of role modeling. Therapists must avoid induction into ideological conflicts, but they can examine therapeutic objectives in the context of traditional versus nontraditional sex roles (Margolin, 1982). For example, they can explore with all family members optional perspectives regarding both instrumental and expressive dimensions of relationships. They can give directives prescribing less familiar behaviors. It may be important to assign a male-female co-therapy team to some client families in order to facilitate exploration and expansion of sex roles.

In addition to helping trainees become aware of their implicit as well as their explicit gender values and behaviors, we need to develop training experiences for developing the less familiar aspect of one's potential, i.e., expressive behaviors for males and instrumental behaviors for females. We could do this by exposing all students to both male and female supervisors, to opposite sex co-therapists, to workshops and conferences addressing gender issues. Helping students to explore the gender issues in their own family genograms as a part of their professional training is another way of dealing with these issues.

In order for these issues to become higher priorities in training programs, it is necessary for the larger organizational systems—the counselor education departments and the colleges in which they reside--to acknowledge the existence of gender issues and their impacts on hiring, departmental policy and actual training. Unfortunately, in this time of cutbacks and consolidation, these issues lose rather than gain ground on the priority scale.

Many males and females have achieved higher levels of androgyny than implied in this discussion. The current generation of students seems to feel more comfortable with role flexibility due to their changing socializing experiences than the generation of today's counselor educators. We may, therefore, end up with generational rather than gender differences, as an aging counselor education staff attempts to train young people whose socialization has been radically different. We all need to open up dialogue across gender and generational boundaries to get more in touch with what Jung (1933) refers to as our "opposite self."

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II. TRAINING AND SUPERVISION

Training and supervision in marriage and family counseling is relatively new to university-based programs. Most programs emanate from clinics and training institutes or in medical schools and departments of home economics or child development. Training students to work with families suggests complex issues above and beyond those associated with individual or group counseling. Traditional supervision, for example, usually focused on two people--the supervisor and the supervisee. Family counseling focuses on several interactive systems: (1) the family system itself; (2) the subsystems comprising the family system; (3) the supervisee/therapist and the family system; (4) the supervisor, supervisee/therapist and the family; and (5) perhaps a group of trainees being supervised along with the supervisee/therapist.

There is no clear methodology of supervision associated with any school of family therapy. Likewise, there is no organized theory focusing on the relationship between treatment and training. Thus, there are varying conceptual and philosophical frameworks underlying the alternative forms of training and supervision in the area of marriage and family counseling.

The articles in this section discuss some of the alternative training/supervisory models currently used in university-based marriage and family counseling programs. They discuss level of structure inherent in the process of supervision, level of hierarchy emphasized in the supervisor/supervisee relationship and formats of evaluation. Some academic departments are struggling with the changes in training and supervisory formats required by marriage and family counseling, whereas others have been encouraged by their colleges and universities to develop innovative practices.

A hierarchical, structured model is described by James Kochalka and Luciano L'Abate of Georgia State University. They believe that a high level of structure is necessary, particularly at the beginning of the training program. This structure may diminish gradually over the course of the training to encourage supervisee self-differentiation and spontaneity. In this model, the supervisor/supervisee relationship is complementary, with the supervisor providing structured intervention strategies and experiences to the consumer supervisee. The philosophical view is that supervisees' anxiety will be lessened with structured tools and training formats and that this enhances learning.

A more collegial process of supervision is described by Margaret Burggraf and Leroy Baruth of the University of South Carolina. This collegial process is characterized by a symmetrical supervisor/supervisee relationship where both participate in a consultation team and learn from each other. The counseling sessions are structured and live supervision is utilized. The collaborative relationship between supervisor and supervisee allows supervisees to develop self-awareness and use of themselves as therapeutic change agents with client families.

James Hansen and Celia Spacone of the State University of New York at Buffalo review the literature and formats of supervision in university-based marriage and family therapy programs. This comprehensive article is unique in its sensitivity to the needs and interests of academic-based programs as they differ from those of training institutes. The authors conclude that the literature is not sufficiently mature to point to any one model appropriate for counselor education departments. However, the authors suggest that a competency-based model might provide the most optimal combination of structure and flexibility.

One of the most popular formats for supervision of marriage and family counselors is live supervision, involving the use of a one-way mirror. About fifteen years old, live supervision originated at training institutes and is now spreading to university settings. Perhaps one of the reasons why it has been difficult for university-based programs to implement live supervision is the lack of adequate physical facilities.

Graduate students George Olin and Diane Risius share their experiences at East Texas State University as supervisees in the process of live supervision, and then Fred Piercy describes his personal feelings and anxieties as the supervisor. It is clear that live supervision produces intensity in both supervisors and supervisees. There are power and pressure issues on both sides of the mirror and it is not easy to ensure that the supervisor, the supervisees, the client family and other trainees achieve creative, self-reliant, competent outcomes.

These articles are designed to stimulate thought and discussion among faculty and students leading to a more careful consideration of the relationship between supervisors and supervisees, between treatment and training, and between the conceptual framework of the training program and supervisory practices.

Clinical Training in Family Psychology

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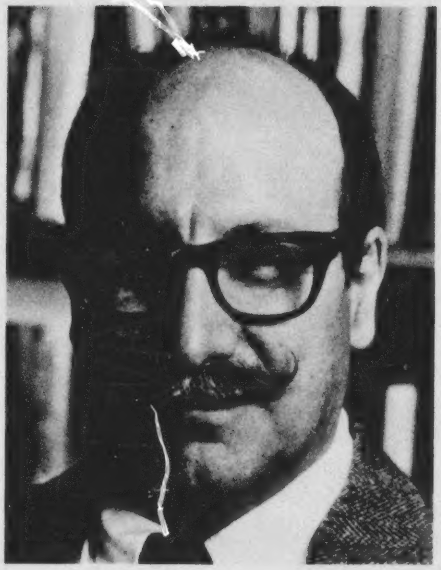

CLINICAL TRAINING IN FAMILY PSYCHOLOGY

In this brief article we will provide an overview of the clinical training program in family psychology at Georgia State University (GSU). Three concepts will be highlighted which serve as the basis for specific intervention strategies; i.e., Structured Enrichment, Covenant Contracting, Intimacy Workshops, and therapy. Actual coursework and curricula will not be addressed in this article but may be found in L'Abate, Berger, Wright, and O'Shea (1979) and L'Abate (1983).

FAMILY PSYCHOLOGY VS. FAMILY THERAPY

The notion of family psychology, still in its infancy (L'Abate, in press), is concerned with the role of the individual as he/she grows and changes within a familial context. Using a developmental life-cycle perspective (Carter & McGoldrick, 1980), one may infer the need for professional intervention to negotiate various transition points; e.g., marriage, birth of the first child, and leaving home. People who are unable to successfully negotiate these life junctures often come with crises to therapists. They are treated using a wide array of unstructured marital and family therapy techniques. These concerns are, of course, within the purview of family therapists. We are in support of this position and promote its improvement through teaching conventional techniques of marital and family therapy. What the family psychology perspective offers that family therapy often lacks is serving couples and families who do not present in crisis, yet still wish to improve the quality of their relational and family life along the entire life-cycle continuum. To this end, students are trained in the more structured techniques of Structured Enrichment, Covenant Contracting, and Intimacy Workshops as a means of addressing the needs of the vast majority of persons who can benefit from intervention of less than a therapeutic nature.

STRUCTURE AND GRADUALNESS

We propose that the concept of structure is the thread that interweaves the elements of the GSU training program. The primary reason for utilizing training elements that range from maximal to minimal structure is that a great deal of structure would simplify the trainee's demands, therefore decreasing the amount of perceived conflict and anxiety. Conversely, a novice's initial experience of very little structure would provoke a great deal of conflict and anxiety. Although empirical evidence does not exist for much of what is done in the name of family therapy training, we can imagine no scenario in which a great deal of initial anxiety would assist the trainee.

The second concept, gradualness, is hypothesized to suggest that the structure be decreased in a systematic fashion. As trainees become more experienced and confident of their ability to interact in a variety of treatment contexts, more is demanded of them to produce spontaneously in the setting (Kochalka & L'Abate, 1983).

ACCOUNTABILITY AND EVALUATION

A critical element of the clinical training in family psychology at GSU concerns the pervasiveness of the spirit of the laboratory method (L'Abate, 1982). The basic principle of the laboratory method, which underscores the training sequence, is the rigorous adherence to a pre- and post-testing format for all clinical interventions that are conducted in the lab. This adherence to evaluation creates an expectation of accountability, which appears to be a necessary, though sometimes neglected, component of clinical training. This focus on evaluation has resulted in student interest in process and outcome research in Structured Enrichment (for a review, see L'Abate, 1981; L'Abate, in press), Covenant Contracting (Caiella, 1982) and Intimacy Workshops (L'Abate & Sloan, in press). Laboratory method procedures have also been utilized in community settings with paraprofessional volunteers (Kochalka, Buzas, L'Abate, McHenry, & Gibson, 1982).

Structured Enrichment

Structured Enrichment (SE) originated within a training context (L'Abate, 1974, 1977) designed to give students an introductory experience with normal couples and families. A fortunate secondary gain has been the demonstrated usefulness of these programs with both normal and clinical populations, thus making SE a legitimate intervention apart from its training value. The basic procedures of SE may be found in L'Abate and Rupp (1981) and Note 2.

The student basically interacts with a couple or a family for eight one-hour sessions: one hour each of pre- and post-testing; six hours of actual enrichment lesson participation. Structure is provided in a very concrete way through use of a manual that contains verbatim instructions for the student to follow in administering the program to the clients. The student is allowed to bring this manual into the session as a visible display to the clients that she or he is not an expert but a facilitator of the planned program, thus keeping performance anxiety to a minimum. The student is also instructed to stay with the manual and defer to the supervisor when clients bring up matters that the student feels incapable of addressing. For example, if one spouse begins to initiate overtly aversive comments to the other spouse, the student is expected to encourage the clients to return to the exercises. The student would report to the supervisor and be advised how to proceed with the clients.

The sequence of a trainee's participation in SE follows the same principle of gradualness noted earlier. First, trainees conduct SE with a mock couple—fellow graduate students who first play the role of client and then the role of enricher. In the second experience, trainees conduct enrichment with "normal" undergraduate couples who are either married or involved in a committed relationship. These students participate voluntarily as experimental subjects. Finally, trainees conduct SE with "normal" nonclinical families who are also obtained through the experimental subject pool (L'Abate, in press; L'Abate & Rupp, 1981.)

Covenant Contracting

The term "covenant contracting" describes a specific method of treatment developed by Sager (1976), by which the couple, with the aid of the trainee, works toward the goal of fulfilling a negotiated behavioral contract (see Note 3). We have modified the format of Sager for our own training purposes by imposing an eight-session limit (i.e., one session each for pre- and post-testing and six sessions devoted to the completion of contracts). Briefly stated, the spouses construct individual contracts that concern self, spouse, marriage, and children. The goal of our form of covenant contracting is the negotiation between spouses of a mutually agreed-upon single contract.

Although the trainee is operating with procedures that can be used by therapists with clinical couples, several elements of our unique adaptation of Sager provide a more comfortable structure for the trainee. The major factor concerns the client population, who are married undergraduates participating in "research for experimental credit." This feature tends to mitigate the potential burden of having to intervene effectively with couples who are presenting in distress. To be fair, however, several couples have participated with thinly veiled relational problems, in hopes of ameliorating their difficulties. The supervisory tactic has been to monitor the trainee's conduct closely during the process and to make a recommendation for marital therapy if that seems appropriate.

Structure is built into the procedures that the trainee follows in the conduct of covenant contracting through session guidelines requiring the completion of certain aspects of the contracts in specific sessions. This adherence to the written and verbalized tasks provides the thrust for each session and allows the trainee to observe marital interaction of a sometimes intense nature while providing an effective means of keeping the session under control. The trainee does this by deferring to the task at hand (i.e., completion of the contracts).

Intimacy Workshops

An Intimacy Workshop is a training strategy in which a male and a female trainee facilitate theme-centered discussions with a group of four to six committed couples. This one-day workshop lasts from four to six hours. The theoretical basis for this procedure comes from L'Abate (1976) and L'Abate & L'Abate (1979). The trainees are guided by the following themes in their conduct of the workshop: (a) acceptance of personal responsibility, (b) differentiation and priorities, (c) learning to negotiate, (d) learning to problem-solve together, and (e) sharing hurts and fears of being hurt. Although the sequence and intended substance of these themes are provided, the trainees must utilize their own resources to carry them out, thereby making this experience the most unstructured in terms of interpersonal demands. The fact that the trainees are leading a group of several couples also adds to the potential for performance anxiety (L'Abate & Sloan, in press).

The inclusion of a group format within the context of a family psychology training program is essential when one considers the increasing need to provide mental health services at reduced costs (L'Abate & Thaxton, 1981). Family clinicians may use the Intimacy Workshop experience as a springboard for creating other theme-focused group activities in which couples and families can engage.

Therapy

The therapy practicum for family psychology students consists of four quarters of weekly group supervisions of marital and family therapy cases that are conducted in the GSU Family Study Center. This is a research and treatment facility which provides services to GSU students and community residents.

Initial telephone contacts are handled by a designated graduate student who obtains basic demographic and problem-related information. A faculty member, who acts as supervisor, then assigns the case to a student, based on case load and appropriate problem-skill match.

Various therapeutic configurations are utilized in the conduct of marriage and family therapy. For example, during the year, the student may see a case alone or with a student co-therapist, be supervised live by a faculty member, or be assisted by a student consultant behind the mirror.

Participation in therapy is, of course, the least structured form of intervention that the student conducts during training and, as such, demands the widest range of skills. Although each of the four supervisors with whom the student comes into contact during this phase of training promotes an eclectic approach, a systems view of problem maintenance and resolution is implicit. Clinical supervisors meet regularly to discuss the student's progress.

CONSUMER REACTIONS

Graduate students in training and clients and students who participate in the range of services in the Family Psychology program compose the constituency of the family psychology faculty. Each group's reactions concerning their involvement have generally been favorable, though often constructively critical of discrete components.

Reaction by graduate students to the structure of the clinical training has been basically positive, with some exceptions noted, depending on the previous experience of the trainee. Those trainees who have had clinical experience prior to entering GSU often chafe at the great degree of structure at the outset of their clinical work. They see themselves as therapists already and are sometimes not interested in learning strategies that can be useful with normal couples or families. Reports from more inexperienced trainees indicate satisfaction with the degree of structure, as the amount of anxiety does not interfere with clinical training.

As for clinical reactions, we have a great deal of data on SE (L'Abate, 1977; L'Abate, Note 1), but, so far, only some case reports of Covenant Contracting and Intimacy Workshops. We will continue to establish a larger data base with all of these intervention strategies.

CONCLUSION

This article provides a flavor of the current state of clinical training in Family Psychology at GSU. The program is comprised of methods of training that are responsive to the changing demands of trainees and receptive to new developments in the training literature. We are in agreement with Kniskern and Gurman's (1979) statement of the field's empirical ignorance concerning the relevant aspects of family therapy training and are making initial efforts toward its improvement (Berger, Kochalka, & Kearns, Note 4).

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3. Procedural manuals for Covenant Contracting and Intimacy Workshops are available upon request from Dr. Luciano L'Abate, Department of Psychology, Georgia State University, Atlanta, Georgia 30303.
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Supervision: A Collegial Process

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SUPERVISION: A COLLEGIAL PROCESS

Clinical supervision of counselors requires continuing synthesis of theory and technique, as well as personal growth in style, manner, artistry and life skills of both the supervisors and counselors. These factors positively influence the supervisory process: clinical experience, structuring skills, and an ability to be in relationships. The third factor, specifically a collegial relationship between supervisors and counselors, is the core component of the supervisory process which we utilize (Burggraf & Lake, 1982).

This supervisory process evolved three years ago from our initial efforts to incorporate marriage and family therapy education into an existing counselor education program. Today, it remains an exciting and challenging dimension of the program. Consistently sought by students, this supervisory process is continuously evaluated as one of their most valuable learning experiences.

The supervisory relationship is one of colleagueship, which we define as a combination of mutuality, respect, and camaraderie. It is a relationship characterized by power and authority vested equally in each of the colleagues. The supervisory process becomes an activity of colleagueship and requires three components: (1) a discipline that is being acquired; (2) a problem which is real; and (3) participants beyond the training community. This activity in turn results in service, which ought to be the essential fruit of the training site (Green, 1981).

The purpose of supervision is to enhance applied therapeutic skills and the person of the therapist. Whatever the level of textbook knowledge, "Competence refers not to the thinking portion, but to the doing portion of therapy" (Loganbill, Hardy & Delworth, 1982, p. 20).

> While the possession of knowledge and technique is fundamental to being a competent therapist, to implement what he[/she] knows does not come automatically with the acquisition of skill. Therefore, I suggest that the training of the person of the therapist is necessary, and that such training primarily address assisting the therapist to know himself[/herself] in the therapeutic context and to learn to use his[/her] personal attitudes, characteristics and experiences in his[/her] work with patients. (Aponte, 1982, p. 20)

The counselors-in-training we supervise are no longer permitted to practice as preparation (role-play) but are expected to practice the art of therapy--practice as performance (Green, 1981). These counselors-in-training are professionals who are subject to the standards of judgment employed by distinguished practitioners. They are in advanced stages of training, believe in their competence as change agents, and willingly and responsibly assume the status of professional colleagues in a supervisory relationship.

Our philosophy of supervision as a learning process comes from the Boston Family Institute (BFI). It is that philosophy which we believe makes colleagueship possible. Like those at BFI, we believe that students learn best:

> When taught in an atmosphere of respect, with a base of safety from which they can take risks.
>
> When taught in their own mode of representation, when the modes of teaching incorporate multiple ways of learning.
>
> When learning takes place from the inside out, attaching what is unknown to what is known, making the strange familiar.
>
> When there is room and validation for having wonderful ideas.
>
> When each person has the opportunity to explore those theories, constructs, hypotheses and concepts each possesses and creates.
>
> When there are processes for integrating and making congruent espoused theories, and the theory-in-use.
>
> When individuals are stretched as persons, theorists, and therapists to increase their range, to innovate, to add on, to make the familiar strange.
>
> When all can be safe enough to take risks of new learning and innovation, and have fun and enjoy the process. (Duhl & Duhl, 1979, p. 62)

THE SUPERVISORY PROCESS

It has been to our advantage to have students seek us as supervisors. The critically important element of collegiality has its beginning prior to the implementation of the supervision model. Our students know and appreciate our work as teachers, therapists and supervisors prior to subjecting what they believe are their tender underbellies to our scrutiny. After the students seek us, we also choose them, thereby assuring an underlying faith in each other, and a mutual respect for and commitment to the rigors of a new learning experience.

Our supervision process is an adaptation of the program developed by Papp (1977), Selvini-Palazzoli (1978), Duhl and Duhl (1979), and Martin, Hiebert and Marx (1981). The process is metatheoretical, drawing on concepts from anthropology, sociology, education, developmental psychology, as well as general systems and family therapy. The clinical supervision occurs with families from outside the training site who have real problems and are experiencing real pain. The counselors-in-training are the professionals from whom these families seek assistance.

The counselors assume a professional role. The counselors-in-training and the supervisors become a consulting team. An additional person, a student in the initial stages of training, is also part of the team. This combination is used to provide a heterosexual therapy team, a colleague backup team and an interested observer.

We see the family once every three weeks for approximately 30 weeks--a total of 10 sessions. This schedule is typical but may be adjusted when necessary. For example, the consulting team may suggest weekly visits for three weeks at the onset of therapy, and then return to the original schedule--one visit every three weeks.

Supervision is live and requires a one-way viewing window, audiotape recording capabilities, and two rooms. A two-hour block of time is necessary. The consulting team meets for 20 minutes in a pre-session to review notes, state hypotheses and testable solutions, and write the counselors' goals both for therapy and for supervision. It is also a time to encourage the team approach. Mutually agreed-to goals prevent the need to confront the counselors, which in turn prevents their need for defensive resistance to the supervisory process.

The family is greeted and meets with the two counselors-in-training. The consulting team model of supervision is explained during the initial session. The family members are told about the team members who will observe the sessions and are asked if they would like to meet them. If they would (and most do), the supervisory team moves into the meeting room momentarily but does not take seats. Each introduces him or herself, welcomes the family, and then returns to the observation room. All family sessions are audiotaped only, to protect the anonymity of the family. At times, however, the consultation sessions are videotaped for training purposes. These sessions include the counselors, supervisors and the student observer.

The counselors-in-training meet with the family for 30 to 40 minutes. Then, they may or may not choose to take a 10 minute consultation break. If the consultation break is taken, all five team members (counselors, supervisors, and student observer) enter the consultation room to summarize the therapy process, discuss therapeutic issues, and share observations and insights. Treatment strategies and session-specific goals are evaluated. The team may formulate a task for the counselors to deliver to the family or generate therapeutic interventions. The counselors may veto any suggestions made by the team.

Team members then return to their positions, and the counselors-in-training share with the family the results of the consultation session. Statements such as "The consultants think..." or "During the consultation break we wondered..." assist the family and counselors-in-training to integrate any new insights. No new material is introduced at this point, but previously discussed material and the consultation session input are processed. Tasks are assigned when appropriate and the next meeting is scheduled. The team then bids farewell to the family, who leaves the clinic.

The consulting team reconvenes for approximately 30 minutes for post-session wrap-up, note taking, and professional cuddling. This session is basically for the team members and is generally characterized by a good measure of humor and caring.

One note of interest which illustrates the creativity and spontaneity of this supervisory process concerns the use of the one-way viewing window. Although we rarely separate the family members, the parents at times want to talk to the counselors without the children present. One such situation involved two adolescents who, when asked if they would mind leaving for a brief period, came voluntarily into the observation room. The parents were told the children were observing. However, they had no objection. To us it seemed a unique way to keep them involved in the therapy process, but in a nonparticipatory role. The parents had already become embroiled in conflict. It was, indeed, the least traumatic way to exclude the children. They were still very much involved—as their comments document.

Observing team members soon learned that the parents revealed no new information to their children. Comments such as "That's how Dad always answers" or"That's just like Mom" were heard. The children also answered the counselors' questions before the parents did. The parents, not having heard their children's responses, merely echoed the children's answers. The children's anticipatory answers were usually incredibly accurate. Such interaction affirms our belief that there is little justification for separating family members--there are few family secrets.

There has not been, as we originally anticipated, a problem with dependency by the counselors. However, less experienced counselors were anxious to escape to the mid-session consultation break, whereas very experienced counselors refused to cooperate and initially did not utilize the consulting break.

The observing team consultants must take care to structure the mid-session break so that it is a professional sharing time. Questions such as "What do we know about the communication patterns of this family?" "What do we know about the maintenance of the system?" "What does the family want to change?" assure that the counselors-in-training remain in charge of the therapeutic process. What they choose to take back into the family session after the consultation break must be only what they can be responsible for and believe in—not what others mandate. The counselors are responsible, competent, and are practicing the art of counseling.

Although by definition supervision implies that the counselors-in-training permit another, the supervisor, to be in charge, our model does not offer any options of abdicating responsibility. We believe such options are, at best, illusions. However, we do understand the hierarchically bound relationship counselors-in-training initially project onto us, but, in fact, our initial purpose is to develop a relationship characterized by collegiality. We define, organize and develop that relationship around the task at hand, that of assisting the counselors to help the family change (Haley, 1976).

EVALUATION

The final component of our supervisory process is evaluation. The counselors-in-training evaluate the process and the team consultants. Although feedback is continuous, counselors-in-training are requested to evaluate their experiences more formally at the end of the supervisory time block. If the process has been effective, there is little new information in their reports.

Live supervision is reported to be important because of the immediacy and effectiveness of the therapeutic interventions. When such interventions redirect the course of therapy, counselors-in-training are no longer defensive but are eager to utilize the talents of the team. The involvement of the consultation team provides the security needed for experimentation, including risk taking, spontaneity, creativity in interventions and constructive confrontation. Independence is a product of competency, which the counselors-in-training report is first evidenced when they anticipate the comments of the team. This supervisory process provides a quality of treatment for the families possible only in a team approach. The counselors-in-training further report that the quality of their learning experience generalizes to their coursework and their personal relationships. Always, there is mention of the importance of their (counselors-in-training) professional status in the clinical setting, and an appreciation for supervisors who are secure in their professional and personal identities.

As supervisors, we evaluate change in the families who work with us. The real proof of the pudding is not simply whether students' behaviors come to resemble more closely those which the supervisor believes to be therapeutic, but whether the clients do, in fact, improve (Matarazzo, 1971). We also evaluate progress toward the desired changes the counselors have specified for themselves. We are affirmed in our process by the waiting list of students seeking supervision and by those who have entered our profession as our colleagues. The goal of supervision is to develop clinicians who can do therapy independently. "Ultimately, the fully competent counselor becomes his/her own supervisor" (Mead & Crane, 1978, p. 69).

> We grow family therapists. We do not make family therapists, nor strictly speaking, do we teach family therapy as a corpus of concepts, tools and techniques. Like good gardeners, we strive to create an environment that is conducive to growth and learning, one that blends spontaneous caring within a carefully laid out plot, that balances sunshine, and of course, a little rain (Constantine, 1976, p. 373).

SUMMARY

Change has been observed and documented by the counselors who have experienced supervision as a collegial process. The stable, adult ego levels of counselors in advanced stages of training require a powerful experience to change and an environment conducive to change (Bernier, 1980). The supervisory process described provides these experiences and such a learning environment.

The change may be continuous, or may proceed in a stair-step manner, or as waves in which forward progress is followed by a plateau where little change occurs (Bigner & Jacobsen, 1981). The change process is controlled by the counselors-in-training. They decide what is to be changed, how much and when enough change has occurred.

Change has been demonstrated in the application of therapeutic skills, achievement of therapeutic and supervisory goals, and enhancement of personhood of the counselor in both the therapeutic and supervisory relationships. Such change is documented by self-report, satisfactory completion of counseling (for the presenting concern) by the families, and the continuing demand for the supervisory experience.

Supervision as a collegial process is credible and believed to be worthy of research as well as clinical application.

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Review of S
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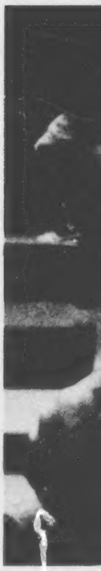

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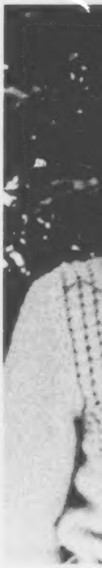

w of Supervision
Family Therapy

James C. Hansen
and
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REVIEW OF SUPERVISION IN FAMILY THERAPY

Supervision is akin to parenting with the first child born to a young couple. Child rearing behaviors are basically "trial and error" and when a crisis occurs, for lack of knowledge of something better, the parents often rely on what their own parents did. Techniques of supervision have at times been of the "trial and error" genre and, when in doubt, supervisors often refer to how they were supervised. In family therapy supervision it is possible to refer to one's individual supervision or the literature on supervision of individual therapy. This is not always appropriate because family therapy involves a radical theoretical shift. Many counselor education programs have recently added family therapy to their curriculum. There is a concomitant need to expand their knowledge and experience in family therapy supervision.

Training and supervision in family therapy has lacked a comprehensive source of information. For years, the training of family therapists was done in an apprenticeship manner in which the trainee worked with a more experienced therapist. A considerable amount of training has been conducted in institutes which propose a particular approach to doing therapy. Liddle and Halpin (1978) identified a number of difficulties for a supervisor interested in reviewing the family therapy literature on supervision. Most articles do not detail the specific methods and procedures that were used in supervision, thereby limiting the usefulness to the person interested in replicating the approach. Further, the ideas in one article are seldom used by other authors so there is no continuous process in transmitting the knowledge or experience. Formal theories of supervision have not been detailed. Therefore, the reader is left to abstract personally useful ideas from a varied literature.

Liddle and Saba (1982) state that most of the recent literature details the clinical components of training with some focus on a supervisory model. However, few descriptions of supervisory models have occurred within academic departments. It seems appropriate for counselor educators embarking on training programs in family therapy to be abreast of the concepts of supervision that have been used in family therapy training, but to be aware that there is no definitive position. This article will present a "state of the field" of supervision in family therapy. Specifically, we will examine the goals, techniques, supervisory relationships, and the evaluation of supervision.

GOALS FOR SUPERVISION

What should be the goals or objectives of supervision in family therapy? Similar to any training program in counseling, the objectives are dependent upon the theoretical assumptions and orientation of the supervisor. However, the theoretical assumptions in family therapy are different from those taught in most counselor education programs. The theories of Freud, Rogers and other typical positions taught in counselor education are not a part of family therapy. The theoretical orientations in family therapy most notably include Minuchin's structural approach, Haley's strategic approach, Bowen's family of origin approach, Satir's growth-oriented approach, Whitaker's experiential approach, Zuk's triadic approach, and the learning theory approaches.

Most orientations in family therapy are based on systems theory concepts of family behavior. A systems approach advocates different sources of dysfunctional behavior, assessment, and intervention techniques from those of an intrapersonal oriented therapy. To use the systems oriented approaches of family therapy, trainees must adopt systems thinking. Liddle and Halpin (1978) examine various perspectives on the socio-political implications of family therapy training being established in a more traditional program. Those wishing to begin a family therapy training and supervision program within a counselor education program will be introducing some different concepts of dysfunction, therapy goals, and interventions.

The goals of supervision are typically to teach the trainee the attitudes and skills needed to implement behavior change according to the approach of the supervisor. Supervisory goals range in emphasis from training specific skill behaviors to an emphasis on the personal growth of the trainee. In training programs oriented toward the structural approach of Minuchin or the strategic approach of Haley, the goals are cognitively based and focus on learning a particular set of skills and ways of intervening with dysfunctional family systems. With a more experientially oriented supervisor using the Whitaker or Satir approach, there is more emphasis on the personal growth aspects of training.

It is not our intention to itemize the possible goals. The goals of supervision are an outgrowth of a family theory and a theory of therapy. A counselor education program can provide a comprehensive coverage of theories and then train therapists in one approach or permit individuals to develop a personal position. In any case, it seems reasonable to establish a competency-based program with objective behaviors to develop. Supervisors can establish minimal competencies a trainee needs and identify methods to evaluate the level of attainment. There are a number of techniques used in supervision that can be used to aid the trainee in achieving the goals.

TECHNIQUES OF SUPERVISION

A basic step toward achieving a useful body of literature on supervision and training in family therapy is the clear and precise identification of the techniques presently in use. Liddle and Halpin (1978) note that such specificity is noticeably lacking. In this section, we will attempt to summarize the major techniques which have been identified in the hope that a coherent summary will facilitate further questioning and study.

Techniques should not be seen merely as "gimmicks" or as the result of an attempt to display "electronic prowess" with the latest video equipment. Rather, a technique should be viewed as a tool: a method that is intrinsically integrated with a theoretical notion and is the logical and most efficient means of achieving a predetermined goal. In order to highlight the necessity of intertwining the theoretical perspective of the supervisor with the technique, we have chosen to outline those techniques of supervision which encompass the larger physical structure and contextual elements which most clearly define a theoretical background. We begin with a review of ex post facto and live techniques, then discuss techniques that vary with the nature of the supervisory unit, and finally, consider the competency-based model.

Context of Supervision

After-the-fact techniques. In this context, supervision is conducted after and separate from the actual therapy situation. The supervisor maintains no direct contact with the family. Depending on the "state of budget" and, at times, personal preference, supervisors have employed ex post facto discussions of therapy based on supervisee recollection, audiotapes or video feedback. Early in the development of family therapy, supervisors borrowed from the individual therapy model of supervision and met with supervisees to discuss either case notes or the social work innovation of process recordings (Liddle & Halpin, 1978). Some authors (Gershenson & Cohen, 1978) have cynically questioned the use of supervisee recollection of a session (written or verbal) as the basis for discussion. "Therefore, it becomes impossible for a therapist to capture accurately and completely the essence of his or her work" (Gershenson & Cohen, 1978, p. 225). Others (Garfield, 1979; Ferber & Mendelssohn, 1968) recommend this method if it is personally comfortable for the supervisor and supervisee.

In an attempt to increase the reliability of content, the supervisee can also make audiotapes of the therapy session and use these as the basis for supervisory discussions. Duhl and Duhl (1979) of the Boston Family Institute, for example, require therapists in supervision to audiotape all sessions but they encourage use of videotape. In fact, while audiotapes are seen as superior to written or verbal recollection, Gershenson and Cohen (1978) note that audiotapes omit pertinent nonverbal behavior.

While it is questionable whether the literature accurately reflects the state of practice, most authors describing after-the-fact supervisory techniques report the use of a videotape playback. Videotape playback is reportedly used in a widely diverse manner. Stier and Goldenberg (1975) use the videotape playback of a session as the basis for seminar discussions by a team that is also involved in traditional case presentations. Kramer and Reitz (1980) employ videotaping as one segment of a larger two-year training program in family therapy at the Center for Family Studies/The Family Institute of Chicago. During this quarter of training, videotape playback of sessions is used in a peer group situation with the goal being increased self-awareness for the therapist. Discussion of the video playback focuses on the therapist's subjective experiences.

Liddle (1980) describes the use of videotape playback as one of a cluster of techniques he uses to facilitate change in the trainee. He finds videotape playback supervision as most effective when the sessions are goal directed. The therapist might be asked to have previously selected a tape segment that can be used as a "representative metaphor" for the therapist's problems in a session. A portion of the tape might also be viewed in detail to have the therapist identify personal style and consider change to a more productive end. The supervisor's role, then, includes not only reviewing the therapist's attempted solutions and suggesting alternatives, but input on an analysis of family dynamics as well. Liddle favors this technique of supervision over live supervision since the time pressures and heightened anxiety of live supervision are reduced. This post hoc analysis may allow for a more complete integration of the learning experience than the hurriedly given and carried out directives of live supervision.

Live Supervision. In line with the trend towards attempting to attain an ever-increasing proximity to the actual therapy situation, "live" supervision has been seen as the most preferred mode by some (Haley, 1976; Minuchin, 1974; Montalvo, 1973). Montalvo, in his classic 1973 article on live supervision in the Minuchin mode of therapy defines this process: "Live supervision is a term describing the process by which someone guides the therapist while he works. The person supervising watches the session usually behind a one-way mirror, and intrudes upon it to guide the therapist's behavior at the moment the action is happening" (p. 343).

The hierarchy in this model is vertical as Montalvo clearly specifies that when the supervisor says "must," the supervisee must comply to the supervisor's demands. Yet, Montalvo cautions for the use of restraint and for letting the therapist continue even after an error as long as he/she is using the error in a useful manner. The role of the supervisor is based on the assumption that any therapist can end up behaving in a way that perpetuates the negative patterns of the family. Yet a supervisor can immediately stop that process and assist the therapist in regaining control.

Variations on the basic process of live supervision have been tried in the years since Montalvo's description of the process. Cornwall and Pearson (1981) describe a technique whereby the supervisor may actively participate in the therapy in a paradoxical fashion by "championing" the family "against" the interviewer. This trend towards more involvement on the part of the supervisor is evidenced in

Coppersmith's (1980a) discussion of the use of the telephone in live supervision. Not only strategic calls to the therapist to re-direct therapy are recommended but also an integration of the telephone into the "normal flow" of the session. Team members call individual family members and family members call each other as well.

Jay Haley, one of the chief proponents of live supervision, uses the telephone for the supervisor to contact the therapist during the session. To avoid misuse of the situation, he offers a contract for supervisor and supervisee to agree upon before interviewing takes place (1977). It covers these points:

1. The supervisor will use discretion and call only when it is felt to be essential.
2. To avoid overloading the therapist, only one idea will be presented in each phone call.
3. Telephone conversations will be concise and brief.
4. Further clarification of the suggestion can be obtained outside the room (the therapist is taught how to exit gracefully).
5. Telephone interventions during live supervision do not center on the general strategy of the case. This can be discussed before the interview or during videotape playback afterwards.
6. The therapist is not surreptitious about the fact that the family is being observed and that the therapist is receiving suggestions.
7. The supervisor normally only suggests, but if, ultimately, responsibility for the outcome of therapy resides in the supervisor, then the supervisor may, in critical situations, deliver a "must" statement to the therapist.

As part of the training program, Andolfi and Menghi (1980) provide the therapist with the experience of working with a family while the therapist is supported by the live supervision of the trainer. Family, therapist and supervisor comprise the "learning system." A group of peers observes as well, but is seen as part of the larger context of the "therapeutic system." The one-way screen separates supervisor and peer group from direct involvement in therapy between therapist and family. Andolfi and Menghi identify four schemes that may occur during the process of therapy:

Scheme One: Supervisor communicates with the therapist by intercom when the supervisor is enmeshed in the family's habitual interaction. Directives are to be immediately employed by the therapist.

Scheme Two: Therapist leaves the room at either his/her own initiative or at the request of the supervisor. The purpose of leaving can be to exchange information, interrupt a non-productive interaction or to clarify an intervention.

Scheme Three: The supervisor alters the therapeutic system by direct intervention. He/she enters the therapy room and interacts with the therapist and/or family.

Scheme Four: One or more of the family members is asked to observe from behind the one-way screen, thereby entering the supervisor-group system.

In spite of the benefits of live supervision, there are those who view it as obtrusive and detrimental to therapist growth. Liddle and Halpin (1978) summarize: "Some common criticisms of live supervision include: Therapist dependency on supervisory interventions, disruption of the therapeutic process, and interference with the therapist's evolvement of his own style" (p. 83). Further, for those involved in counselor education programs, there are practical considerations. Even Haley (1976) who calls live supervision the "most effective" form, also notes that it is the "most expensive" as well. Supervisors need to be available for the actual session rather than on their own schedules. Live supervision has traditionally been done in institutes of family therapy where the physical accoutrements (observation rooms, telephones, one-way mirrors, video equipment) are readily available. Live supervision further implies that a training program either has access to a caseload of families or develops an outpatient clinic. Neither option is without administrative complications. To make a commitment to a model of live supervision, a counselor education program needs to be willing to invest time, money and energy.

The Supervisory Unit: Individual vs Group

Along with differences in when supervision occurs, variation exists in who is to be included in the supervisory unit. This can range from including only the supervisor and supervisee to including peers or team members. With these variations, there also occurs variation in primary responsibility for the therapy and in who makes direct contact with the family. Birchler (1975) notes the relative benefits of the traditional supervisor-supervisee dyad in either the ex post facto modality or with the supervisor as co-therapist with the supervisee. Inherent in the supervisor as co-therapist model are several advantages and disadvantages. While the supervisee can benefit from observational learning, the temptation is there for the supervisee to defer to the status of the supervisor and participate less in the session. This model also brings with it all the advantages and disadvantages of live supervision.

Congruent with systems theory notions, a larger part of the "teaching/learning ecology" (Heath, 1982, p. 187) is often included as part of the supervisory unit. Peer groups of five or six members, each with one or two supervisors, are the main supervisory unit of the Ackerman Institute (LaPerriere, 1979). Peer group supervision as conducted in an experiment at the Philadelphia Child Guidance Clinic is defined by two of its proponents (Hare & Frankena, 1972): "This is a process by which a group of young professionals who meet regularly to review cases and treatment approaches without a leader, share expertise to take responsibility for their own and each other's professional development and for maintaining a standard of clinical service" (p. 527).

They found in a comparison of two groups that a group composed of individuals with similar amounts of experience, however diverse, was superior in enhancing free sharing and reducing unhelpful criticism and a lack of cohesiveness. Haley (1977) demands that criticism not be offered unless it is joined with a positive alternative.

Peggy Papp (1977) uses an interdisciplinary team format for group supervision in a Brief/Strategic model influenced by the Milan Group (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1974). The team meets before each session to outline overall and session-specific goals. The session is conducted by one therapist but observed by the entire team. During the session, the therapist leaves for a consultation with the team during which a directive for the family is devised. After the session, the team meets to review the session and devise future strategies. Thus, the team functions in a supervisory as well as in a therapeutic fashion, but does not physically participate in the session.

Heath (1982) summarizes the advantages and disadvantages of group supervision and training in the live supervision mode particularly. On the positive

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side he cites the advantage of learning through observation; feelings of group membership and support; and the added input from a variety of observers. On the negative side, he notes that group members get significantly less personal feedback time. While group members in his experience are less likely to criticize each other, Heath finds a tendency toward a "risky-shift" in suggested intervention techniques. The group tends to suggest interventions that are high in creativity but which are, at times, seen as "too crazy" to implement and definitely riskier in a cost/advantage ratio.

Stier and Goldenberg (1975) note the saving of the supervisor's time as an advantage to group training and supervision. They also contend that the group experience facilitates movement of the student's orientation from an individual to a systems approach. Trainees and supervisees in the group are able to reenact the family experience and to benefit from the individual member's contact with a large variety of families.

Competency-Based Model

An emphasis on clearly defined behavioral objectives characterizes the training program developed by Cleghorn and Levin (1973) at McMaster University. They have identified three areas into which the requisite skills can be classified:

1. Perceptual: The emphasis is on "the perception of interactions and the meaning and effect of them on family members and the family system" (p. 441).
2. Conceptual: This includes specification of family rules of behavior and an awareness of the interactions among family relationships.
3. Executive: These skills are developed by the therapist to influence the family towards either an enactment of their functioning or an alteration of behavior patterns.

For the three areas, Cleghorn and Levin have identified objectives to be met by therapists at basic, advanced and experienced levels of functioning. The checklist of comprehensive and detailed behavioral objectives provides a clear, unbiased, systematic approach to training at all levels.

Using the three skill areas of Cleghorn and Levin as a basis, Tomm and Wright (1979) compiled a more precise outline of behavioral objectives for the family therapist. Their model is organized at three levels of therapist activity: functions, competencies and skills of the therapist. The four major functions of the therapist are:

1. Engagement: "establishing and maintaining a meaningful working relationship between the therapist and the family" (p. 228).
2. Problem identification: the continuing process of assessment.
3. Change facilitation: interventions.
4. Termination: "relinquishing the relationship."

Therapeutic competencies in the form of instructional objectives for training are listed for each area of functioning in a sequence of how they logically might occur in a typical interview. Tomm and Wright have revised Cleghorn and Levin's three skill areas into two intertwined skill areas: perceptual/conceptual (what occurs in the therapist's mind) and executive (what the therapist does). In supervision, observation of the latter is felt to lead to exploration of the former.

While the model represents a noteworthy attempt at identifying the skills of a family therapist in a form that is inherently "teachable," the final step has been left out. Tomm and Wright do not address the manner in which the skills are to be taught. What is needed is integration of these objectives into a clearly defined training program. The instructional objectives provide an initial framework which needs further definition of how it would be used in a training program.

The work of Street and Treacher (1980) is such an attempt to intertwine a list of skills components with a model of teaching that has proven to be effective in individual therapy supervision. For their skill components, they combine elements from the work of Minuchin and Haley, observation of videotapes of their own work, and Kniskern and Gurman's (1979) attempt to identify factors consistently demonstrating positive effects in the literature. As a method of teaching, they have transferred Ivey's micro-training approach from individual therapy to use with trainees and supervisees in family therapy.

The essence of the Street and Treacher approach is "that a general skill which is to be taught is broken down into its component skills which are defined in a precise behavioral way" (1980, p. 245). This is a direct, didactic approach which the authors feel is readily adaptable to any theoretical school. Street and Treacher assume that the trainee can and should focus on the mastery of one discrete skill at a time. This is done first through observation of prepared videotape demonstrations of each skill and reading a detailed, practical manual selection. Secondly, the trainee is given an opportunity to practice the skill in a role play situation which is videotaped and reviewed with the supervisor. Role playing is thought to be most productive and economical when done in a peer supervision context. In this fashion, trainees are able to experience good and bad therapy from the client's point of view. While Street and Treacher are presently producing a set of materials (videotapes, manuals) for the microtraining package, they have included a sample from their manual in their 1980 article. The Enactment and Reenactment skill is defined, and guidelines for a behavioral demonstration of the skill are listed as well as traps to avoid in producing the skill. When one notes the vast amount of research the Ivey microcounseling training materials have generated, a similar development in family therapy is most welcome.

THE SUPERVISORY RELATIONSHIP

The issues in the supervisory relationship in family therapy training are somewhat different from those we characteristically read in counselor education journals. Some characterize the relationship as a hierarchy (Haley, 1976; Minuchin, 1974; Montalvo, 1973), some describe it as egalitarian (Ackerman, 1973), while others emphasize a need to explore a therapist's nuclear family or family of origin (Bowen, 1978; Coppersmith, 1980b). The structural and strategic approaches emphasize that there must be a hierarchy in the training program just as there is in therapy. Haley (1976) maintained that just as in therapy "one cannot be directive," in supervision "one cannot have a hierarchical trainer-trainee relationship." Proponents of this position believe that it is an error to deny or minimize this directive aspect and the hierarchical nature of the supervisor/supervisee relationship. This is clearly emphasized in the goals and techniques used with this therapy approach.

Minuchin (1974) also supports the hierarchical relationship in supervision. Based on a theory of therapy that problems in families develop when hierarchical boundaries are transgressed, supervisors working from this perspective believe that when the hierarchical nature of the relationship is broken, the efficiency of both the supervisor and supervisee is diminished. Both the structural and strategic approaches to supervision and the supervisor-supervisee relationship are oriented to the task at hand, that of teaching the therapist skills to help the family.

The supervisory relationship may involve consideration of the trainee's family or family of origin as a part of personal growth. Some programs emphasizing a more psychodynamic or experiential orientation place emphasis on the importance of the trainee resolving feelings about the family of origin. Several authors have suggested the involvement of the trainee's spouse in a type of marital therapy as a part of the training program (Guldner, 1978). Others have emphasized the importance of the therapist differentiating him/herself from the family of origin. Obviously, the individuals at the more skill-oriented end of the continuum are less interested in any form of personal therapy as a part of the training program.

Bowen and his followers use a form of supervision which is unique and appropriate for his form of therapy. Just as family members are guided through "family voyages" in order to differentiate themselves from their family of origin, trainees are required to make similar journeys under the tutelage of their supervisor. Supervisors are encouraged to work on their own differentiation to serve as a model for the trainees. This demonstrates a willingness to be open about oneself and an attempt to personalize the process of supervision.

Ackerman's (1973) approach to the supervisory relationship stated that the relationship of the trainee to the supervisor was egalitarian, not hierarchical. Psychotherapy and supervision were seen to be democratic processes. He believed that while differences of opinion occur in supervision, supervisors and trainees should actively resolve their differences and share their feelings in process-oriented ways. Ackerman's emphasis on empathy as an important aspect of the supervisor/supervisee relationship is more similar to the more traditional counselor education concepts.

Although no one speaks specifically to the concept of modeling, it is apparent that each of these approaches to supervision emphasizes the fact that the supervisor is a model of therapy for the therapist to follow. Kniskern and Gurman (1979) conclude that whatever approach is used, "the pragmatic upshot is still the same: trainees learn by what they live in the immediacy of their interaction with their supervisors" (p. 87).

The relationship in supervision may proceed through a series of stages. Johnson (1961) described the following stages of the supervisory process from the trainee's developing perception of the supervisor: (1) judge-evaluator, (2) evaluator-helper, (3) evaluator-helper-confronter, (4) unjust judge-withholding "father," (5) fallible person like all others, (6) teacher-helper rather than judge or all-giving object of dependency longings. Ard (1973) thought supervision would involve two professionals whose roles change over time. The relationship moves from the roles of an apprentice and mentor to one where supervisor and supervisee are finally peers.

Gershenson and Cohen (1978) offer the unique perspective of evaluating live supervision in a Haley framework from the point of view of the supervisee. Their personal experience as supervisees leads them to identify three stages in the process: (1) Anxiety and resistance. This stage is marked by distrust of the observers, anger and fear of being judged by the supervisor. A chance to observe the supervisor doing therapy on videotape marked the end of this stage. (2) Increased emotional involvement and reduced verticality. Behavior change preceded understanding for both the family and the supervisees. The hierarchical nature of the supervisor/supervisee relationship began to dissipate, and they turned toward functioning more as a team. (3) A cyclic process begins whereby the supervisees are able to take the directives of the supervisor and use them as an impetus for their own conceptualizations of the case. This report tends to validate the stages of Johnson and possibly Ard.

EVALUATION OF SUPERVISION

After reviewing the research on family therapy training, Kniskern and Gurman (1979) state "We have to confess our fields' collective empirical ignorance on this topic" (p. 83). In fact, although they discuss the concept of supervisory methods, no specific studies regarding supervision are identified in their review. They can go so far as to state that there exists no research evidence that training experiences in marriage and family therapy, in fact, increase the effectiveness of clinicians. They do note, however, that there are specific therapist factors that influence the outcome of family therapy, and that those factors are teachable and learnable and therefore provide indirect support for the effectiveness of training.

Liddle and Halpin (1978) comment that the slow rate of progress in training program evaluation is in part due to the complexity of this area. Training programs have seldom fully described their objectives, content, and procedures, which makes replication difficult. The field of family therapy has, in general, been advanced through the work of charismatic leaders. However, if the field is to advance further, the work of these masters must be quantified.

Kniskern and Gurman (1979) identified some important researchable questions regarding family therapy training. The basic question is "What types of training experiences are especially potent in producing effective therapists within a particular model of therapy?" With regard to supervision, they asked six specific questions: (1) When are audio- and videotapes most helpful? (2) When are they harmful? (3) What are the demonstrable advantages and disadvantages of co-therapy supervision? (4) What are the measurable strengths and weaknesses of problem-oriented supervision and of therapist-oriented supervision? (5) Should all cases be supervised? (6) What differences do different forms of supervision make on different trainees?

Liddle (1982) reported there is some recent research that is relevant to supervision. He also raised concern about the essentials of research—reliability and validity as they relate to evaluation in training. The question of reliability concerns the degree to which the evaluation can show the training is predictable, dependable, and consistent, so that it can be replicated by different trainers and different trainees. If the supervision model and techniques are not reliable, the training effects would be specific to only one trainer and one training site. The issue of validity questions whether trainers teach their trainees what they think they do. In addition, one questions the kinds of assessment criteria and instrumentation that are useful in this research. Liddle raised another interesting question about supervision in this field. If evaluation is about a specific theoretical model, should we research each model on the same or different criteria? Could we identify generic evaluation criteria which transcend differences in therapeutic models?

CONCLUSION

Counselor education programs that are attempting to initiate family therapy components are in the favorable position of lagging slightly behind in the birth of this field of therapy. These educators can take advantage of the "trial and error" attempts of others and minimize the "error" element. The research in this field is not sufficiently mature to offer conclusive evidence about the supervisory process. However, several models, particularly the competency-based models, seem promising and appropriate to a counselor education program. They provide the combination of structure and flexibility essential to a training program for counselors.

Several factors can be offered for consideration to those faculties attempting such a development. First, we would stress the importance of realizing that family therapy is a systems theory. The implications of this fact are far-reaching and all-encompassing and require a dedication to these principles by those supporting the program. Second, in adopting a supervisory model, it is crucial to remember the syntonic nature of a theory of therapy and a theory of training. One's assumptions about therapy and how it is to be conducted ought to be reflected in how one supervises. Unfortunately, there are economic considerations which must be made. While one may find a particular supervisory set-up attractive, it would be a mistake to undertake a project for which adequate staff and funding were not available to see the project to its conclusion.

Finally, in a university program beginning a family therapy training model, it is imperative that the staff receive specific training in family therapy. The faculty will no doubt be influenced by the supervision they receive. It is important to go one step further and institute a training program for supervisors. Since we are beginning these programs on the knowledge base of past experience, we would be highly remiss if programs were not designed with evaluation as an integral component.

We have the opportunity, as we "parent" this new generation of family therapists, to borrow from the past, but also to change, redirect and challenge old models for our purposes. It is an opportunity which should not be missed.

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Live Supervision: The Supervisee's Perspective

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LIVE SUPERVISION: THE SUPERVISEE'S PERSPECTIVE

There is a growing body of literature concerning the potential benefits of live supervision (Coppersmith, 1980; Haley, 1976; Minuchin, 1974; Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967; Minuchin, Rosman, & Baker, 1978; Montalvo, 1973; Papp, 1980; Watzlawick, Weakland, & Fisch, 1974;). During live supervision, actual therapy is taking place while a team comprised of at least one supervisor and one or more student therapists is observing the process through a one-way mirror. A videotape might be made of the session in order to allow the primary therapist and the team to review the session and make suggestions. A phone connects the therapy room to the observation room, and calls are made from the supervisor to the therapist suggesting various interventions. The student therapist may also call the team if help is needed.

The team approach to live supervision has many creative applications (e.g., Coppersmith, 1980; Palazzoli, Boscolo, Cecchin, & Prata, 1978). For example, the team might communicate a different view regarding the likelihood that the client/family will follow a given directive. This tactic may move an oppositional family to prove the team wrong, thus moving the client/family in the direction of positive change. The supervisor may come into the room to assist the student therapist. Conversely, the therapist may leave the room to seek help from the team. During the session, the team may pass notes under the door to suggest ideas to the therapist. Interventions might take place after the formal session has ended. For example, the supervisor may speak to the client/family. As the name implies, live supervision is a lively process!

Traditionally, live supervision has been written from the perspective of those behind the one-way mirror. While the value of live supervision seems compelling, the internal struggles of the supervisee are often underemphasized or overlooked entirely. Often feeling anxious and inadequate in the role of therapist, a supervisee may be asked to give directives he or she may not fully understand or be comfortable with, perhaps to a difficult and hostile family. Gershenson and Cohen (1978) have been among the first to describe their experiences as supervisees. Following their lead, we would like to relate our experiences, both as a means of increasing supervisor empathy and as encouragement to our peers who are beginning the process.

Live supervision has evolved for us in three distinct stages. The first stage was that of anxiety and bewilderment. This anxiety evolved from our belief that the experience would be both growth-enhancing and threatening. We wavered between both beliefs and were relieved to learn that our peers did too. At first, our friends seemed convinced that it was not safe to openly admit these feelings. Although we were excited about the new possibilities for growth, our anxiety still demanded expression.

One of our primary concerns centered around the evaluative aspect of supervision. Although we recognized that this was inevitable, we were uncomfortable with the seemingly subjective method by which each session was evaluated. We wondered how our final grade would be determined. Our own feelings of inadequacy also surfaced when we compared ourselves to our peers. (Eventually we gave ourselves permission to develop at our own pace.)

It would have been helpful to observe an experienced therapist, but these opportunities were generally rare. Our bewilderment was further intensified by having three supervisors. We learned from three distinct perspectives which also served to confuse us at times. Integrating three different therapeutic styles was not an easy matter. We feared that to reject any one was also to reject our supervisor. With one's own theory of change barely conceived, and being "double bound" in relationships we could not escape, no wonder we were feeling a little klutzy!

The second stage was essentially one of a dual resentment. Having gained some confidence and having experienced the process, we wanted to test out our own ability to do therapy. This opportunity was granted, but when we exhausted our own ideas, frequently more suggestions were provided than we could process. We thought that if we had no alternatives, we were obliged to carry out the team's suggestions. Notes were often passed under the door to us, and we were often taken out of the driver's seat when a supervisor would enter the session. Perhaps most resented were the interventions that were made at the end of the formal sessions. While we could see the value of these multiple points of view to the family, we could not help feeling somewhat intruded upon. We felt usurped and depowered, like junior partners in the therapeutic process.

The other half of the resentment was self-directed and involved feeling too dependent on the rest of the team. This feeling was exacerbated because we knew that team support would not always be available. We felt an adolescent-like ambivalence towards the team's help--we were partly very angry at still needing to have frequent and direct guidance, and we partly wanted continued assistance and felt fearful of venturing out alone.

Acceptance was the final stage of the supervision. Finally, we began to establish a matrix upon which to base our interventions. We came to a point where we began to feel comfortable with winning the battle for structure with the team as well as the client/family. While supervisor suggestions and calls were still numerous, we began to accept or modify those suggestions that seemed to be useful, and disregarded (hopefully politely) those that did not fit with our goals and style. Even if no alternatives were immediately obvious to us, we did not accept ideas that did not fit our style and emerging theory. We learned to trust ourselves and not expect to always have a goal in mind. During this stage, we began to feel like we were getting somewhere. Although our supervisors had told us we were improving, we had not felt this way ourselves. Doing therapy became enjoyable for us. We had begun to feel competent and in control.

Having gone through the process of live supervision, we now believe that there is no substitute for it. It is difficult to imagine now how a supervisor could help us with a case if he/she does not see us working with it. Simply discussing a case with our supervisor leaves out so much, especially what we ourselves are doing to maintain or alleviate the symptoms.

We would like to offer the following suggestions to supervisors, which we hope will enhance the experience of live supervision:

1. Familiarize the supervisees with the team approach concept before clients are seen.

2. Provide a concentrated experience initially to allow the student therapist to begin developing his/her personal theory and style. (We would define a concentrated experience as having a small caseload with many opportunities for varied supervision.)

3. Plan social activities to enhance the esprit de corps among the supervisees.

4. Provide a caseload that allows the supervisee to stay busy but is not overwhelming.

5. Provide many opportunities for supervisees to observe others doing therapy.

6. Allow opportunities for cotherapy with other team members (including the supervisor).

7. Establish the ground rule that therapeutic intervention suggestions may be given by the team (via phone or notes) during actual therapy, with the agreement that the supervisee may use them at his/her discretion.

8. Explain that the supervisor's entrance into the session is not a negative reflection upon the supervisee's abilities.

9. Expect and communicate overtly that the supervisee will probably feel anxious during the live supervision process.

We hope that this paper will give supervisors a better understanding of the process from the supervisee's perspective. We also hope that the presentation of our experiences will help other supervisees become accepting of the "not-so-strange" feelings they may encounter during the supervision process. The team taught us an important idea: to lean on them when we need to, but also to trust our own judgment. You are there with the family--the team is observing. Your intuition can supplement your developing skills. Remember, the team is there to help you.

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Live Supervision: Reflections of a Supervisor

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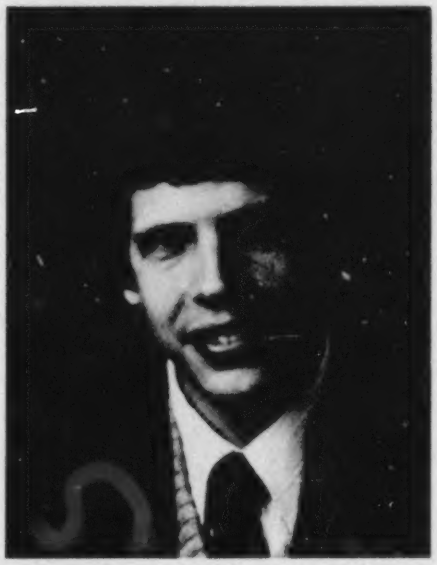

LIVE SUPERVISION: REFLECTIONS OF A SUPERVISOR

In the previous article, Olin and Risius recounted their difficult, yet rewarding, experiences with live family therapy supervision. As one of their former supervisors, I will share my own experiences from the other side of the one-way mirror. Since the nuts and bolts of live supervision are presented in detail elsewhere (Abroms, 1978; Berger & Dammann, 1982; Birchler, 1975; Coppersmith, 1980; Heath, 1982; Kempster & Savitsky, 1967; Meyerstein, 1977; Montalvo, 1973), this paper will focus instead on my own personal evolution as a family therapy supervisor.

Like many counselor educators, my first experiences providing supervision involved listening, along with my supervisees, to endless audiotapes of individual counseling, injecting sage comments at appropriate times. I would occasionally roleplay skills, and would sometimes ask questions which (I hoped) would tie theory to practice.

I thought I was doing a good job and reacted with righteous indignation to my first exposure to live supervision at an APGA family therapy workshop. An experienced structural family therapist described watching from behind a one-way mirror as supervisees worked with families. If a supervisee was getting "caught in the system," the supervisor would call with a suggestion from a telephone in the observation room to the supervisee's telephone in the therapy room. This seemed to me to be an odd, rather disrespectful thing for a supervisor to do. Such a procedure might undermine the confidence and effectiveness of the supervisee and create an unhealthy dependence on the supervisor. Also, the examples of messages the supervisor gave seemed callous. One "level one" directive was, "Change seats with mother and tell her to shut up and quit interrupting her son." This response seemed rock bottom in terms of warmth and empathy, and as subtle as most mothers'-in-law suggestions. After that workshop, I was sure I would never recommend structural family therapy or live supervision to any of my loved ones!

However, I valued openmindedness. My work with families in the past had taught me that a permissive, nondirective approach to family therapy could be disastrous. I attended a few more workshops led by skilled and sensitive family therapists, read a few good books, and observed creative colleagues engaged in live supervision. After a developmental period of a few years, I even started referring to myself as a family therapist. Systems theory began to fit for me as did the interventions of strategic (and structural!) family therapists. I began to teach courses in family therapy. As for live supervision, I still had my doubts, but if I had to listen to one more inaudible audiotape....

I tiptoed into my first experiences with live supervision. I would make very few calls to the therapist, but plenty of asides to students with me behind the one-way mirror about such things as the function of the system within the family, reciprocal patterns of interaction and possible interventions. It was a wonderfully direct vantage point to understand human behavior. The students seemed to think I knew what I was talking about, but I knew I was playing it safe. I had the capability to provide much more direction through phone calls, mid-session conferences, and other direct interventions when the supervisee drifted or became overwhelmed. Slowly, but resolutely, I became more active during the sessions.

As my active interventions increased, so did my doubts. When should I intervene? Am I doing this right? Sometimes I was not sure what to do. Being in the middle of the drama of family therapy was exciting, but the responsibility weighed heavily on me. Providing direction, being decisive, being sensitive, and allowing the supervisee freedom for the direction of a session were not all possible at the same moment.

It was at this point that I began to learn to balance the core conditions of my counselor education training with the more directive family therapy supervision that I was starting to appreciate. I could change the focus and direction of a session with a well-placed phone call and still remain caring. I did occasionally wonder how Carkhuff would rate what came out of my mouth. I would suggest, for example, "Tell Jane that the supervision team is concerned that she has a lot to lose if she stops making decisions for her husband, George. As it is now, she can mother him, but doesn't have to risk getting close enough to be a wife." Odd? Disrespectful? It did not feel like it. There was always an element of truth in any paradoxical directive I suggested, and the supervision was making an impact. Students started seeking out live supervision experiences with me. We became explorers together.

It occurred to me along the way that if my students were courageous enough to be observed conducting therapy, so should I. This realization came a lot sooner than did my offer to be observed! But I did it. I had stage fright, but learned the advantages of live supervision from the therapist's point of view (my students, to my surprise, relished the chance to call me on the phone). I learned to regard the team as a source of support, as did the families with whom I worked. My own competence and confidence grew with their involvement.

Of course, even today I cannot say I am always sure of everything I do in live supervision. But the process and I are becoming friends. My growing comfort with live supervision comes from my discovery that I do not have to give up my humanness or compassion to make directive interventions. The families I observe are usually unhappy people stuck in painful patterns that can be broken. It is a good feeling to directly see these patterns change as a result of a phone-in or tactic planned with a supervisee. And no more boring audiotapes! Supervision is becoming a creative, collaborative process that stretches me and my students.

I expect that some readers will be skeptical of live supervision; this is probably healthy. For those open enough to give it a shot, here are a few hints:

1. Read first, both on family therapy (e.g., Haley, 1976; Minuchin, 1976; Minuchin & Fishman, 1981) and on live supervision. As you make the leap (or crawl, as it was for me) from linear to systemic thinking, the techniques of live supervision will begin to make a lot more sense.

2. Attend workshops on live supervision. There is nothing like watching a skilled supervisor in action to give you a feel for the process--and to charge you with the excitement and courage to try it yourself.

3. Begin with a team of supervisees and/or colleagues that have also been exposed to the process of live supervision. Discuss with them how phone-ins, conferences, messages and other approaches will be used. It is important to be on the same wave length regarding expectations.

4. Discuss the freedom supervisees have to reject or not reject supervisor directives. I believe the freedom to reject directives empowers the supervisee. If the team has a collaborative set, this freedom is not often abused.

5. Expect to feel uncomfortable at first. Any technique is alien until you have personalized it--until you and it become one. That will happen.

It is not easy to begin using live supervision, but there are many payoffs. I have not presented all the advantages here (cf. Haley, 1976; Kempster & Savitsky, 1967). What I have tried to communicate relates to the excitement and energy I have felt embarking upon this challenge, and the potential usefulness of life supervision for the families we serve. Good luck as you begin your own adventure in live supervision.

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III. ALTERNATIVE FAMILY LIFESTYLES

Most training programs in marriage and family counseling focus primarily on the conventional two-parent nuclear family. The implication seems to be that the same processes and intervention strategies can apply to different family constellations. There are few courses or supervised fieldwork experiences focusing on issues associated with alternative family lifestyles.

The two articles in this section provide a unique focus on divorce and single parenting. Whereas the literature abounds with articles concerning general training issues of marriage and family counselors and the issues associated with the practice of working with divorcing couples and single parent families, there are few, if any, articles dealing specifically with the training issues pertinent to the process of divorce and single parenting.

Harold Hackney of Purdue University differentiates between divorce and marriage counseling in his article "Training the Divorce Counselor." He cites three levels of skills necessary for effective divorce counseling: (1) crisis intervention; (2) mediation; and (3) psychological adjustment. He describes specialized knowledge and competencies crucial to the training of counselors working with divorcing families.

In this same vein, Samuel Gladding of Fairfield University and Charles Huber of the University of North Florida postulate the issues and training guidelines pertinent to single-parent family counseling. Since the proportion of single-parent families is rapidly increasing in our society, they believe that counselors must be alerted to the uniqueness of this family format and must be encouraged to learn how these families are similar and how they are dissimilar to two-parent families. It follows then that treatment objectives and intervention strategies for single-parent families may be different from those for two-parent families.

As marriage and family counselors expand their understanding of alternative family lifestyles, they need to articulate the relevant training competencies and knowledge base required for effective helping. The field of marriage and family counseling is continuously evolving and yesterday's alternative family lifestyle becomes today's norm. This means that training programs and models need to be flexible and adaptive to societal trends.

Training the Divorce Counselor

Harold Hackney

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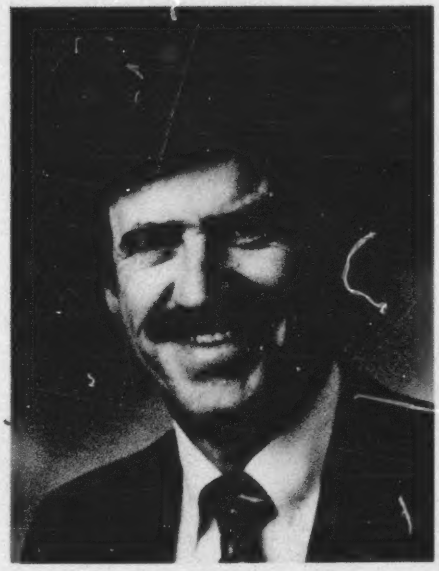

TRAINING THE DIVORCE COUNSELOR

Two inescapable realities face the counseling profession as we enter the decade of the 1980's. The first is the acceptance of divorce by our society as a viable alternative to unhappy marriage. The second is the growing presence of divorce counseling as a professional subdiscipline. Olson, Russell, and Sprenkle (1980) acknowledge this new subspecialty and credit its emergence to the incidence of divorce in the 1970's and to "the growing awareness that divorcing individuals need help uncoupling and dealing with this process" (p. 985). In the only comprehensive review of the practice, Kressel and Deutsch (1977) reported that

> ...well-defined training programs for specializing in divorce work do not exist. Recruitment...can occur by numerous routes, of which training in individual or marital therapy, child psychiatry, and counseling are among the more common. (p. 417)

Traditionally, divorce counseling has been associated with marital and/or family therapy, but Brown (1976) observes that "marriage and family therapists receive little training that prepares them to understand the divorce process or to assist their divorcing clients" (p. 403). Indeed, there can be cases in which the marriage/family therapist encounters value conflicts when confronted with irretrievable breakdowns during marital counseling.

WHAT IS DIVORCE COUNSELING?

One of the more troublesome issues for the marriage counselor is the differentiation between marriage counseling and divorce counseling. Often the counseling process begins as marriage counseling or as individual counseling for which divorce is not an option or is the undesired option. However, as conditions change or crystalize, divorce becomes more of a reality for one or both spouses. As a general guideline, divorce counseling can be said to exist at that point when one or both spouses make the determination to end the marital relationship. This decision is not necessarily made by the person who is the identified client. However, the transition from marital, family, or individual interpersonal counseling to divorce counseling creates a shift of focus from relational involvement to relational disengagement.

WHO DOES DIVORCE COUNSELING?

Lazarus (1981) has observed that "Divorce, if properly orchestrated by a specially trained therapist, can be a liberating experience that promotes, rather than undermines, family solidarity" (p. 15). Who are these "specially-trained therapists" who deliver such services? In a recent nationwide survey of divorce therapy practices (Hackney, 1981), 49% of the respondents had the equivalent of a Master's degree, either in counseling, social work, or theology. The remaining 51% possessed a doctorate either in counseling/clinical psychology (43.5%), psychiatry (1.5%), theology (3.7%), or other related areas (2.2%).

These statistics indicate that different levels of therapy training do not determine who provides divorce counseling services. The theoretical orientation is equally diverse. Thirty-one percent of the respondents indicated that they used a multiple (two or more) therapy approach; another 30% expressed a preference for an eclectic orientation; psychoanalytic theory was preferred by 11.7%, followed by client centered (5.1%), gestalt (4.4%), behavioral (3.6%), existential (3%), structural family therapy (3%), transactional analysis (3%), strategic family therapy (1.5%), and other or no theoretical orientation (3.7%).

WHERE DOES DIVORCE COUNSELING OCCUR?

Unlike most forms of counseling, divorce counseling is not available to most segments of the population. Kressel and Deutsch (1977) have noted that

> Apart from the opportunities for litigation, there are no highly visible, well-structured public agencies or procedures for the resolution of conflicts arising out of the termination of the marriage contract. (p. 415)

While court-mandated counseling is a current practice in some states and localities, the focus tends to be on saving the marriage rather than facilitating the adjustment to divorce. Today, in some larger cities, private divorce counseling centers are beginning to appear. An increasing number of churches are becoming aware, also, of the problems of divorce adjustment among parishioners and are starting to offer limited services.

GOALS OF DIVORCE COUNSELING

Divorce is best conceptualized as a process rather than an event. The divorcing person faces the task of letting go of a previous lifestyle, creating a relatively stable, but temporary, transitory lifestyle, and ultimately moving toward a new more permanent lifestyle. For the person in this process, three types of counseling intervention are indicated: crisis intervention, stabilization, and rehabilitation and personal growth. In a smaller number of cases, there can be a fourth focus, intensive psychotherapy.

Crisis intervention is the typical first goal of the divorce counselor. Initial emotional reactions to divorce must be resolved, including denial, guilt, anger, depression, and rejection. This early stage of counseling is characterized by intense psychological stress drawing from such sources as "feeling unlovable" (Kressel, 1980); narcissistic injury (Rice, 1977); or separation stress (Weiss, 1975).

Beyond these emotional issues lies the necessity of letting go of the former life and turning toward an uncertain new life. This stabilization stage, typified by "non-psychological stresses" (Kressel, 1980), involves such issues and decisions as change of residence, change in employment (or to employment), adjustment in parenting responsibilities and contacts, establishing new social networks, and establishing economic stability.

The third goal of divorce counseling is to help the client develop a new sense of self-worth, of personal goals, and of future promise. At this level the client is building upon rehabilitative decisions and developing a new sense of personhood. The counselor seeks to help the client interpret these new life experiences, and to identify potential life experiences that would be dissonant with older, inappropriate self-views. This is a period of considerable self-growth and future orientation.

Finally, there are instances in which post divorce issues are inappropriately attributed to the divorce. The person may have entered marriage with dysfunctional characteristics and exited the marriage with the same, though perhaps intensifed, conditions. For this client, the counselor must be able to identify the real issues and offer psychotherapy appropriate to the problem. Each of the defined interventions, and this intervention in particular, suggest that the counselor must possess specific competencies in order to offer counseling to divorcing clients.

LEVELS OF COMPETENCE

Several authors have begun to suggest that there are specific skills associated with divorce counseling (Brown, 1976; Kaslow, 1981). These skills can be classified into three distinct levels of competence. The first (or introductory) level includes divorce related **crisis intervention and personal adjustment skills.** The mode of service delivery at this level tends to be either individual counseling or structured intervention. Competencies characteristic of this level include: knowledge of general crisis theory; knowledge of divorce adjustment stages; skill with supportive interventions; knowledge of group support programs and group interventions; diagnostic skills; and referral skills.

Level Two competencies involve **divorce mediation interventions.** The mode of treatment may be individual counseling or couple counseling (Sprenkle & Storm, 1980). Issues range from deciding to divorce to how the divorce shall be orchestrated. At this level, competencies include: mediation/negotiation skills; knowledge of judicial practices in the award of property and/or custody decisions; knowledge of alternative post divorce lifestyles (including co-parenting); knowledge of the growing body of research on the impact of divorce upon children and adults; and a personal awareness of counselor biases that would prejudice the mediation/negotiation process.

Level Three incorporates the post separation **psychological adjustment skills.** The mode of treatment typically is individual counseling/psychotherapy, although it can also include a modified family therapy approach, particularly when a child has become the identified problem. Competencies include psychological diagnostics; short-term therapy skills for depression; knowledge of antidepressant medications and their side effects; suicide intervention skills; intensive psychotherapy skills; and family therapy skills.

TOWARD A MODEL FOR TRAINING

The model to be described presupposes that the entering trainee will have completed a minimum of a Master's degree program in counseling as a precondition for admission. The training model may be inserted either as a post Master's program or as part of a doctoral level program. Having been divorced is neither a sufficient qualification nor a prerequisite for entering the training program.

Level One Training

At the introductory level, two courses comprise the didactic/experiential sequence. The first course, a divorce seminar, has five objectives: (1) to acquaint the trainee with the body of professional literature on divorce and divorce adjustment; (2) to examine the "theories" of divorce adjustment, postulated social causes, proposed interventions, and future trend projections; (3) to examine the dynamics of divorce adjustment and the impact on children and extended families; (4) to examine social and legal networks as they relate to the divorce process; and (5) to become acquainted with the various divorce group workshop formats that are used with adults and with children. In achieving these objectives, the divorce seminar provides sufficient foundation knowledge to allow the trainee to enter an experiential phase, the group/individual practicum in divorce.

The practicum experience contains two activities. First, trainees are assigned to lead a ten-week "Divorce Adjustment Workshop" which emphasizes educational and skill building issues rather than therapeutic issues. This author prefers the Fisher Divorce Adjustment Group model (1978), although there are a variety of other alternative models. Group participants are solicited from the community and are screened via intake interviews. Trainees perform the intake screening. Each of the ten weeks in the workshop has a topic focus. Concurrent with the workshop, trainees also provide individual divorce counseling to group participants. Trainees are expected to accumulate 20+ hours of group leadership, 10+ hours of topic preparation for the group sessions, 20-30 hours of individual counseling with group participants, and 10-15 hours of supervision during the practicum.

Level Two Training

At the intermediate training level, the focus is upon interventions that facilitate decision-making skills and reduce the negative consequences of the adversarial legal process (Bernard & Hackney, in press). A single course that combines didactic and experiential modes best serves the objectives of this level, which are: (1) to introduce the trainee to concepts and skills of the divorce mediation process (Coogler, 1978; Irving, 1981); (2) to identify current divorce law practices, nationally and locally; (3) to acquire an understanding of the history of divorce law practices in the United States; (4) to establish lines of communication with local attorneys, judges, and mediation services; and (5) to participate in divorce mediation services in a practicum-like setting.

In the didactic portion of this course, the trainee learns to differentiate between mediation, binding arbitration, and voluntary arbitration. The trainee is introduced to the three stages of mediation and their implied skill components (Initial stage—Exploration; Intermediate Stage—Problem Solving; and Final Stage—Resolution). Divorce law practices are examined (e.g., Bass & Rein, 1976) and interpreted by local attorneys and judges through panel discussions and interviews. Finally, societal, regional and local practices and prejudices are examined for their effect upon the mediation process (e.g., local formulas for determining child support and alimony; prejudicial positions for the award of child custody, etc.). As trainees develop awareness and skills in the mediation process, they may become involved as interns in a mediation service (either in the local community or as part of the training program). Trainees are encouraged to affiliate with the Association of Family Conciliation Courts, an international association of judges, counselors, attorneys, and others concerned with court-connected family counseling services.

Level Three Training

In some respects, this level of training is not precisely a divorce counseling orientation. The nature of training is that of a doctoral level counseling or clinical psychology program in that the focus is upon assessment, diagnosis, prognosis, therapy, and evaluation. The reason training is placed within this context is two-fold. It is this author's belief that doctoral level training without a divorce counseling foundation is an inadequate preparation for assisting a significant minority of divorcing clients.

Similarly, a divorce counseling orientation without some advanced diagnostic and therapeutic skills is also inadequate preparation.

Thus, it is assumed that the trainee entering the third level of training has successfully negotiated Levels One and Two. At this point, the issue becomes one of working with specific psychological dysfunctions. Typical among these are chronic depression, drug abuse, potential suicide, anorexia nervosa and bulimia, dependent personality disorders, and other borderline personality disorders. Clients suffering from such problems experience the divorce as an excrutiatingly painful ordeal which exacerbates latent symptoms and prolongs the adjustment process. These clients are truly in pain and are often desperate for relief.

Level Three trainees should be prepared to function as family therapists as well as individual therapists, and should be able to work with systems, either strategically, structurally, or both. Such competencies would require courses in family therapy theory and practicum.

DISCUSSION

There is little question that divorce is a family related problem and that divorce counseling is within the domain of the marriage and family therapist. Yet until only recently, divorce counseling has been treated as the unwanted stepchild of the family therapy discipline. On the other hand, there can be no question that divorce adjustment is an individual's problem and frequently requires intensive individual counseling. A dilemma arises from the fact that individual-focused counselor training programs, if they have addressed the issue of divorce at all, have done so in the context of individual counseling only. In the same manner, marital/family therapy training programs have focused on the family complications caused by divorce and have overlooked individual psychodynamics. Consequently, divorce counseling has fallen between the cracks of the therapy training floorboards even as the divorce rate continues its unrelenting annual climb.

It is time that we turn our attention to this problem. The person seeking divorce counseling should have reason to believe the counselor will be trained in this type of helping. Professional counselors need to begin defining counselor competencies, training criteria, training models, and service delivery modes to address the problem.

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Single-Parent Family Counseling: Issues and Training Guidelines

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SINGLE-PARENT FAMILY COUNSELING: ISSUES AND TRAINING GUIDELINES

The single-parent family is a growing phenomenon in American society (Gatley & Koulack, 1979; Henderson, 1981; Lynn, 1977). In the past decade, the percentage of single-parent families in the United States with children under 18 has increased from 5.3% to 7.3% (Macklin, 1980). While this increase in itself might normally go unnoticed, the change is significant when one considers that the percentage of married couples with children under 18 declined during the same decade from 40.3% to 32.4% of United States households. Thus, single-parent family constellations increased considerably compared to the percentage of what has traditionally been considered the typical American family form. One report noted an increase from 25% to 40% in some elementary schools, a percentage approaching 60% in the proportion of children representing single-parent families (Ber' & Seavey, 1979). Not only are the number of single-parent families still growing rapidly, but "at a greater rate than any other form of family" (Horne & Ohlsen, 1982, p. 2).

While the number of single-parent families may be increasing, counseling issues centering specifically on these families have either been given a lower priority or, for the most part, presented in a fragmented, indirect manner. Two lines of investigation have been the prevalent focus in the area of single-parent family issues. The first approach has focused mainly on the children of single-parent families. Investigations and publications in this area have been prolific. For example, studies by Blanchard and Biller (1971) on father availability and academic performance of boys, and Hetherington (1972) on father absence and personality development in girls are representative of this line of inquiry. However, as Blechman (1982) stated, "four decades of research have not provided conclusive information" (p. 179) about whether children from one-parent families are more at risk than children from traditional nuclear families. Thus, most of the investigation into this child-centered approach has yielded inconclusive results. The one main "off-shoot" that has come from this area of consideration has been the "guide books" (e.g., Gardner, 1970) that are directed at helping children understand the processes of separation, divorce, and remarriage.

The second investigative approach considering the single-parent family has concentrated its attention on single parents themselves. This line of inquiry has explored everything from the competency of single fathers (e.g., Orthner, 1979) to the longitudinal effects on both parents of divorce (e.g., Wallerstein & Kelly, 1980). The popular spinoff of this research has culminated in "how-to" and "what-to-do" books for single parents (e.g., Murdock, 1980).

While both of these approaches have examined important variables within single-parent families, they have failed to produce a viable and comprehensive framework for counseling with such families. Indeed, this area of interest has been all but ignored. The purpose of this presentation is to attempt to begin to fill that void by focusing on a set of primary issues counselors might be asked to consider when beginning work with single-parent families.

COUNSELOR TRAINING

In order to work effectively with single-parent families, counselors must realize the uniqueness of this family lifestyle when compared to the nuclear family. It is only when such a delineation is made that counselors can come to accurately understand both the personal and professional issues connected with these families, and implement strategies to help them resolve any difficulties and work to enhance their future potential. We have found four major issues to be primary in our own clinical work with single-parent families and that of our students whom we have trained in the classroom and supervised in the therapeutic setting: developmental perspective, theoretical approach, counselor activity, and personal awareness. We will consider each of these four issues separately.

Developmental Perspective

The first issue to consider in preparing counselors to work with single-parent families involves helping them distinguish between developmental or transitional and more permanent psychological problems that a family might experience. The issue of developmental/transitional versus permanent psychological problems is one that is usually dealt with as a regular part of most instructional programs for traditional family therapists. This type of training, however, needs to take on a more extensive focus when dealing with single-parent families because of the many different variables that tend to disrupt and disturb this family form and because of the lack of resources many of these families have for coping with stress situations. For instance, Wallerstein and Kelly (1980) have described crucial first-year factors such as greater stress and strain on the custodial parent's capacity to parent that are common to most single-parent family's development. This type of difficulty is most often transitional as the parent and children soon learn to restructure the family system. Many difficulties that would normally be cause for concern in the nuclear family (e.g., depression) can and should be viewed developmentally as signs of readjustment (at least for a while) in single-parent families.

One major developmental issue we have found counselors working with single-parent families consistently encounter is that of "boundaries." Almost all family therapies deal with boundaries. Yet, in single-parent families, the issue of boundaries is especially crucial to understand from a developmental perspective. Single parents have been found to have an initial strong tendency to overinvest themselves in their children (Combrinck-Graham, Gursky, & Brendler, 1982; Wallerstein & Kelly, 1980). This overinvestment frequently leads to enmeshment and an arrestment of normal developmental processes in both parent and child if not addressed appropriately. If there is one crucial developmental task that all single-parent family members face, it is the job of delineating who they are both individually and corporately. Counselors must be particularly attuned to this issue of boundaries, especially as they are redrawn and renegotiated within a recently fractured family unit.

Thus, counselors may need to reframe their outlook on this family form as to what may be a developmental transition and what may be more permanently debilitating. Working with single-parent families on the problems of depression, loneliness, and anger may be quite different from dealing with these issues within a traditional intact two-parent family. In training, it is important that counselors become cognizant of this fact and do not overreact impulsively to a temporary problem.

Theoretical Approach

A second issue counselors must address in working with single-parent families is their own theoretical orientation to family therapy. While many counselors-in-training seek to be "eclectic," this desire pales when they realize that this approach all too frequently results in their not being well enough versed in any particular theoretical orientation. At the present, approaches to family therapy have not hardened into specific schools (Okun & Rappaport, 1980). The field is also one that has a limited number of approaches. If counselors are to work most effectively, they must first master a dominant theoretical approach to working with families (e.g., communications, structural, strategic) and employ this approach within the context of where a family is developmentally. At this time, structural family therapists appear to have done the most in working with single-parent families (e.g., Minuchin & Montalvo, 1967). The critical point is that a counselor find a theory compatible with his or her personality style and workable with single-parent families. If this procedure is followed, counselors will not only know the reasons behind their behaviors in the therapeutic setting, but also be quite clearly focused as to where they are headed with particular families.

Counselor Activity

A third important factor for counselors working with single-parent families to address is the directiveness of their therapeutic interventions. Consider the importance of communication within the single-parent family. Cashion (1982) stated that single-parent families "may require the development of communication and listening skills...very different from communication styles frequently found in the two-parent hierarchical family" (p. 83). In order to function most effectively, the single-parent family may often need also to adopt a more democratic, cooperative family structure than has been their norm. Even in adopting this type of structure, the family may still use old, ineffective communication patterns of an earlier time and different circumstance. Thus, counselors must learn to directly teach new communication patterns and to facilitate democratic movement within the family. The concept of the counselor as teacher and mover is alien to many training texts that describe the role of the counselor.

Related to the issue of teaching is the concept of advocacy. In working with single-parent families, counselors must also be advocates. Unike the nuclear family, single-parent families more often experience insecure socioeconomic situations. This is especially true if the head of the family is female (Wallerstein & Kelly, 1980). If counselors are to be most effective with these families, they must play an active role in working with other community professionals such as lawyers, employment agencies, welfare agencies, etc. (Cashion, 1982). The single-parent family is especially limited in how well it can function under the impact of environmental stressors.

The role of advocate is one that counselors who work with single-parent families must come to understand and practice. The role does not require counselors to become a surrogate parent to the family, but rather to work as a catalyst between the family and helping agencies until positive interaction takes place. This is a proactive role and one that may not be used nearly as frequently with intact, two-parent families or individuals. Examining how counselors feel about assuming this role and helping them develop the skills to implement the role are additional, critical component issues in training individuals to work with single-parent families.

Personal Awareness

The final primary issue that should be considered in training counselors how to work with single-parent families is the considerable public bias against one-parent families (Blechman, 1982). Even though the percentage of single-parent families has grown significantly in recent years, this family form is still a minority. Of special importance to would-be counselors of these families are their own thoughts and feelings. Counselors, like everyone, have both subtle and blatant prejudices. If not recognized, these ideas can manifest themselves in a detrimental way within counseling sessions. Certainly, a counselor who grew up in an intact two-parent family may feel that this form of family life is to be preferred or is indeed superior to the one-parent family forms. This type of thinking may lead the counselor to perceive the single-parent family as "abnormal," "sick," or "inferior." Such labels may block effective therapeutic intervention that would otherwise occur. The same kind of irrational thinking and feeling might also occur with counselors brought up in unhappy single-parent households.

To counteract this thinking, counselors should be encouraged through the use of self-awareness experiences such as completing a genogram or other concrete device to explore their thoughts and feelings about their own families of origin. This kind of exploration ought then to lead to counselors examining their thoughts and feelings on alternative family life styles. If conducted properly, irrational and prejudicial feelings may be ferreted out. It is critical that those who would counsel families go beyond the mere recognition of their own unresolved family of origin difficulties, especially if they are to be effective with single-parent families.

CONCLUSIONS

Resnikoff (1981) conceptualized ten key questions for understanding the family as patient. We note this in concluding our presentation as his questions are applicable to one-parent, as well as two-parent families. The value in employing these questions, according to Resnikoff, is to help the learner gain a clearer picture of how the family operates. We have similar purposes in raising the four primary issues we have just addressed. Our intent is that counselors not only consider how a single-parent family is generally functioning, but that they further come to focus on the unique therapeutic considerations necessary to work effectively within a single-parent family system. It is our belief that consistent therapeutic effectiveness in dealing with single-parent families can be an attainable goal if the unique aspects of these families can be established.

In training counselors to help constructively resolve the problems and enhance the future potential of single-parent families, we proposed that this form of family life be viewed as a uniquely developing system. Furthermore, we recommended that counselors be quite clear theoretically and conceptually as to their focus and goals in working with single-parent families. We suggested the importance of taking a directive teaching stance where appropriate and stressed the value of being an advocate for the family. Finally, we identified the critical importance of personal awareness in recognizing potential biases in regard to single-parent family forms. With the continued growth of single-parent families, the issues raised herein will surely increase in importance, especially for counselors who wish to be competently prepared to work with multiple family forms.

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